INFLUENCE OF THERAPISTS' GENDER AND PROFESSIONAL AND PERSONAL EXPERIENCE WITH INFIDELITY ON THE PROMOTION OF DISCLOSURE OF AFFAIRS IN THERAPY

By

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DEDICATED TO THE MEMORY OF

Stephen Julius Nittolo

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INFLUENCE OF THERAPISTS' GENDER AND PROFESSIONAL AND PERSONAL EXPERIENCE WITH INFIDELITY ON THE PROMOTION OF DISCLOSURE OF AFFAIRS IN THERAPY

By

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Infidelity is pervasive in the clinical population of couples. The Infidelity Perspective Survey (IPS), and the Infidelity: Clinician Demographic Questionnaire (ICD-Q), were developed. The IPS contains 11 hypothetical relationship dilemmas with second-person items, and measures a clinician's tendency to promote disclosure. The ICD-Q solicits demographic information, like gender, and items for three subscales—Clinical/Professional Experience with Infidelity (CEI); Personal Experience with Infidelity (PEI); and Family of Origin Experience with Infidelity (FOHI).

Clinical Members of the American Association for Marriage and Family Therapy (AAMFT) responded to the IPS' 62 items, and wrote-in additional responses. Both the IPS and the ICD-Q were field tested for validity and reliability through expert opinion (N = 11), piloting (N = 37), and the main study (N = 227).

Pilot and main study IPS' internal consistency was computed at .73 and .81 (Cronbach's Alpha), respectively. Pilot and main study internal consistency (Cronbach's Alpha), respectively, of the CEI scale was .67 and .73, of the PEI scale was .56 and .61, and of the FOHI scale was .94 and .97. The instruments proved sufficiently reliable.

The effects of the independent variables, and their two-way interactions, on clinicians' tendencies to promote disclosure in therapy, were examined. A 2 x 2 x 2 x 2 between-subjects analysis of variance determined no influence when G, CEI, PEI, and FOHI were examined for main effect. There was a small effect size when G and PEI interact, male therapists *with* PEI showing a lower tendency to promote disclosure during therapy than female therapists *with* PEI, and male therapists *without* PEI showing a higher tendency to promote disclosure than female therapists *without* PEI.

There was a marginal effect size when CEI and PEI interact, clinicians *with a high level* of CEI and *with* PEI showing greater tendency to promote disclosure than respondents *with a low level* of CEI and *with* PEI. Additionally, respondents *with a high level* of CEI and *without* PEI showed a lower tendency to promote disclosure than respondents *with a low level* of CEI and *without* PEI. The study's limitations and future implications, and a summary of written-in responses, are set forth.

CHAPTER 1
INTRODUCTION

Opening Statement

Stories about love, passion, and betrayal make for interesting telling and listening. For some, when love and/or commitment goes awry, they find their way into therapists' and counselors' offices—angry, brokenhearted, crestfallen, and hopeless. For others, their experiences in the therapist's office can create a new brand of pain, one that results from learning previously unknown traumatic information about elements of their partners' secret lives.

The discovery or the disclosure of an extramarital (outside of marriage), or of an extradyadic or extrarelationship (outside of exclusive relationship), affair creates intense, conflicted, inconsistent energy in clients, and typically precipitates a major crisis that can put the individuals and/or the relationship at great risk (E. Brown, 1991, 1999; Glass, 2002, 2003b; Glass & Wright, 1988, 1992; Guerin, Fogarty, Fay, & Kautto, 1996; Lusterman, 1995, 1998; Schneider, Corley, & Irons, 1998).

Despite her position on the importance of the disclosure of current and/or ancient affairs during couples therapy, E. Brown (1991, 1999) cautions that the disclosure of infidelity within a couple's relationship entails serious costs that must be evaluated in advance of disclosure taking place, including the heightened probability of destructive and violent behavior (Brown 1991; Kaslow, 1993). E. Brown urges therapists to thoroughly think through the repercussions of disclosure before taking action. Others

take a similar position on the issue (Humphrey, 1987; Moultrup, 1990; Pittman, 1987; Weiner-Davis, 1992).

Schneider, Corley, and Irons (1998) published a study (n = 82, 82 sex addicts and their partners, respectively) reporting the results of their international survey of 164 recovering sex addicts and partners with respect to their "survival" of the disclosure of infidelity in their relationships. They learned that disclosure tended to be a process and not a one-time event; that disclosure was most conducive to healing when it included only the major elements of the infidelity and not all the "gory details"; that despite half the partners threatening to leave the relationship at the time of disclosure, only one quarter of the partners actually left; that when slips and/or relapses occurred (more infidelity), new decisions about disclosure had to be made; that neither disclosure nor threats to leave prevented relapses; and that, with the passage of time, 96% of addicts and 93% of partners came to believe that disclosure had been the right thing to do (versus 58% and 81% of addicts and partners, respectively, when polled at the time of disclosure).

Schneider, Corley, and Irons (1998) discovered that, following disclosure, the betrayed partners tend to need a great deal of additional support from professionals and from friends (beyond their needs preceding disclosure) and that honesty is a crucial healing characteristic for couples in therapy.

To assist therapists working with couples in dealing with the disclosure of extramarital sexual activity in their relationships, Corley and Schneider (2002) and Schneider and Corley (2002) offer guidelines that enable the clinician to lead clients, through the disclosure, and then through the aftermath of the disclosure. Additionally,

Schneider (1989) offers useful interventions to therapists working with clients as they rebuild their marriages during recovery from compulsive sexual behavior.

Herring (2001) provides ethical guidelines for the treatment of compulsive sexual behavior and suggests that therapists be skilled in the six core concepts (informed consent; competence through a sound theoretical foundation; confidentiality including the clear understanding of duty to warn/protect, HIV issues, family secrets and involvement; maintenance of appropriate boundaries through clear understating of own cultural and personal values, self-disclosure rules, touching, and sexual attraction to clients; and appropriate supervision) when they attempt this work.

When therapists travel the terrain of couples counseling with the bewildered couple or a member of that couple, they find themselves drained by the demands of the work. It is especially important that clinicians be prepared for the roller-coaster, then the moratorium, and then the rebuilding phases of the process that invariably ensues when couples decide to stay together following the discovery or disclosure of an affair (Olson, Russell, Higgins-Kessler, & Miller, 2002; Rhodes, 1984).

In addition to the couples grappling with infidelity, the third leg of this intense relationship triangle (the other woman, the other man), who is also part of the web of deceit (Guerin et al., 1996; Lusterman, 1998; Richardson, 1985, 1988; Staheli, 1995; Tuch, 2000) and who also may be hurt as a function of an affair, often makes his/her way into therapists' and counselors' offices in need of healing and repairing. Sometimes, his/her individual therapy evolves into couples therapy and creates a dilemma for the therapist, who now knows secret information that has not yet been disclosed to the other partner. At this point, the therapist must decide if he/she is comfortable treating this couple and must decide how to handle the secret information.

Sometimes, the other man or the other woman is involved in both a committed relationship of his/her own *and* an extra-dyadic relationship as the third leg of a triangle in someone else's committed relationship, and so can be a betrayed and/or betraying partner of his/her own exclusive committed relationship. Although this dynamic can provide more equality between and safety within the space of the two people in the extra-relationship affair, it also creates a more complex therapy case (Moultrup, 1990; Richardson, 1988).

When individuals and couples enter therapy of their own volition, they typically intend to work on themselves and/or their relationships and indeed understand that honesty is important to the process. Yet, despite their commitment to communicating openly and candidly with their therapists and with their partners, they nonetheless hold back information about their extramarital, extradyadic, or extrarelationship involvement. Or, they might desire to keep this information secret from their partner(s) while sharing it with the therapist, expecting the therapist to keep the information secret from the unsuspecting other member of the couple.

Therapists and counselors must remember that, as times have evolved, the milieu of sexual standards in society has shifted (Manji, 1996; Melton, 1968), as have the faces of couples (Gurman & Jacobson, 2002; Jacobson & Gurman, 1995; Johnson & Lebow, 2000). The term "couple" is no longer reserved for people who are engaged or married. Today, couple conjures up images that include many forms of attachments. Currently, many people openly commit to exclusivity with each other by simply declaring their love to one another, or by living together and ignoring the legalization of their relationships.

Young and Long (1998) observe that, as a culture, America endorses committed relationships. The most current census (U.S. Bureau of the Census, 2003) supports this

observation (N = 105.5 million households; 54.5 million married couples, plus 5.5 million couples living together, including gays, but not married).

Rathus, Navid, and Fichner-Rathus (2000) summarize studies on homosexuality that reveal that, in the United States, France, and Denmark, between 3% and 11% of men and between 2% and 12% of women identify themselves as gay or lesbian. They also report that between 1% and 4% of the population is bisexual (sexually responsive to either gender), and possesses an erotic attraction to and an interest in developing romantic relationships with both males and females.

Despite the lack of widespread legal sanctioning, homosexual couples (males and females) have become more visible within mainstream society and are considered to have the same committed relationship status (especially emotionally) as do heterosexual couples who are either cohabitating or dating seriously, but who are not legally married.

The Census Bureau (2003) reports, notably, that of the total 105.5 million households in the United States, 1% belong to homosexual couples living together. Infidelity is as much a therapeutic issue in these relationships as it is in heterosexual couples (Green & Mitchell, 2002).

Sexual identity can play an important part in the life of families and couples (Green & Michell, 2002; Johnson & Colucci, 1999; Laird, 2003; Green & Boyd-Franklin, 1996). Pittman (1987) points out that many people can heterosexually perform, maintain a heterosexual relationship with the opposite sex (maybe a marriage), prefer the benefits of a heterosexual lifestyle, but have greater sexual emotional and sexual comfort with their own gender. They may in fact lead a double life in which they are heterosexually married or committed and are also involved in a secret extramarital/extradyadic affair, or might be in a committed relationship with a member of their own gender and be involved

in an extradyadic relationship with a member from the opposite gender. When this dynamic is learned or acknowledged (either through disclosure or discovery) by the unsuspecting partner(s) and the couple (either the heterosexual couple or the same gender couple) goes to therapy, added layers of complications become part of the healing process. Therapists and counselors can benefit from this awareness and must also challenge their own belief systems so that moral judgment is minimized in the therapy room (American Psychological Association [APA], 1992; Melton, 1968).

Malcolm (2000) conducted a study on the sexual identity development of behaviorally bisexual married men. According to Malcolm (2000), it was originally found that between 1.3% and 1.9% of heterosexually married men report homosexual behaviors, and that, in most of those cases, the behaviors remain a secret from the wife. Malcolm (2000) himself found that improved psychological adjustment followed marital separation in those men in his sample ($n = 355$) who were more homosexually oriented than the rest. Perhaps those men benefit from separation or divorce more than from rebuilding the marriage. For the wife, the discovery of the existence of this lifestyle in her husband's life can catapult her into a frenzy of negative emotions that, at best, might be susceptible to being stabilized at an inconsolable level. There is much at stake when a therapist encourages either the betrayer to disclose his affair, or the spouse to discover her husband's affair.

It is not the legal attachment or the sexual orientation of the members of the couple that determines the level of pain each feels when betrayed by the person he/she loves. Rather, the depth of the attachment, the emotional expectations, and the beliefs about exclusivity create the traumatic reaction in the partners.

Clinicians' offices are filled with clients who suffer from a wounded heart that results from the advent of infidelity in their lives and from the unique interpretations those clients make about the experiences in their lives (Walsh, 2003), irrespective of their legal status or sexual orientation. Therapists are part of the process that leads clients to new levels of being. How the therapist discharges this awesome responsibility and the factors that influence his/her actions warrant examination.

Factors Influencing Therapists' and Counselors' Stances in the Therapy Room

Gender

The literature is prolific on the issue of gender as it pertains to infidelity, and especially as it pertains to the gender of clients (Buunk & Bakker, 1995; Kinsey, Pomeroy, Martin & Gebhart, 1953; Lawson & Samson, 1988; Sprecher, Regan, & Mckinney, 1988; Wiederman, 1997).

The sex of a person (male or female) is typically genetically determined (Worden & Worden, 1998). In the Postmodern tradition, Farganis (1994) points out that gender is not something that is a given but rather is a "historical constellation of sex traits" (p. 103), and socially constructed (Gergen, 1991, 1994; Faucault, 1995). In the stereotypical sense, men tend to be seen as dominant, rational, objective, independent, competitive, decisive, and aggressive (Worden & Worden, 1998). Women, on the other hand, have traditionally been seen as submissive, caring, affectionate, cooperative, emotional, relationship-centered, domestic, and nurturing.

Because gender is the most basic issue of diversity, Worden and Worden (1998) point out that a therapist's role requires a range of behaviors that cross the stereotypes of gender roles. Although this might be true, therapists are not always able to transcend

their own realities and are therefore likely to behave (male or female) according to the social context of their life's experiences.

Newberry, Alexander, and Turner (1991) examined the effects of therapist and client sex roles on the behaviors of participants in family therapy. Their research design included examining two-parent families (n = 34), half of which received treatment from male therapists-in-training (n = 17), and half from female therapists-in-training (n = 17). After transcribing the sessions, and dividing the insession behaviors into units, they concluded that, despite their initial finding that there were no gender differences, a contingency analysis detected different gender-linked sequential dependencies of therapist and client behavior. They suggest that female and male therapists may, due to their gender, experience different types of difficulties in filling the role of therapist.

For example, they suggest that socialization patterns may encourage male therapists to perform from positions of authority more often than would female therapists. Female therapists may implicitly challenge the male's role or his behaviors in the family and in the couple. Infidelity is especially at risk for this type of bias inasmuch as more males than females engage in infidelity, and so a therapist would more frequently treat clients where the male is the betrayer. Male clients may have more difficulty accepting authority from the female therapist, and so if/when a female therapist has a strong tendency to dictate to clients what should happen during therapy, the male client might challenge her authority. If men tend to be more forceful than women, how does gender influence the therapist's tendency to promote the disclosure of an affair during couples therapy?

Clinical/Professional Experience with Infidelity (CEI)

Basic counselor training addresses the importance of therapists preparing to enter their therapy rooms with some fundamental skills, and with cognizance of their own biases and values (Ivey & Ivey, 1999). Some have gathered the opinions of expert marriage and family therapists with regard to what specialized skills are believed to be necessary to deem a therapist prepared for his/her work (Figley & Nelson, 1989, 1990; Nelson & Figley, 1990; Nelson, Heilbrun, & Figley, 1993).

As therapists become seasoned, Jensen and Bergin (1988) and Keller, Huber, and Hardy (1988) suggest that they focus on developing a personal theoretical orientation that includes the exploration of values in family therapy theories, as well as the exploration of the values and the stance the therapist exhibits during therapy sessions. This is especially true with an issue as socially controversial as infidelity. If therapists are to position themselves as suggested by the Marriage and Family Therapy (MFT) profession's guidelines and ethics (American Association for Marriage and Family Therapy [AAMFT], 2001), so as to "let" clients make decisions for themselves without exercising undue influence, then therapists must become mindful, and remain so throughout the therapeutic process, of those factors that influence him/her.

Hubble, Duncan, and Miller (2000) offer extensive insight into what works in therapy. They point out that, typically, a therapist's level of experience does not enhance the therapeutic relationship. Yet, at the same time, the more experienced and the more intensely trained therapists are, the more they are able to understand their clients' experiences with therapy. It follows then that the more exposure a therapist has with those clients who participate in affairs (the betrayed, the betrayer, the other man, the other woman), the more experience that therapist will have with the issue and the

dynamics of the work. Perhaps this suggests that the more seasoned therapists are, the more they are able to appreciate the client's experience and, at the same time, the more they are able to keep an open mind when controversial issues, such as infidelity, present in their therapy rooms. It is logical to deduce that an experienced therapist might be more likely to remain facilitative, and not forceful and/or domineering, as he/she plans and executes interventions.

Clients, in their relationship with therapists, tend to attribute expertness to them; and so clients may very well be willing to let their behaviors be overly influenced. Because of this dynamic, therapists can often freely exert power over clients. Society teaches its members that experience translates into expertness.

In view of the foregoing, if a client perceives a therapist as being experienced in the area of infidelity, that client might attribute expertness to that therapist and might relinquish his/her own right to make his/her own decisions about his/her life to that therapist. If a therapist tends to be forceful (have a high tendency to promote disclosure), then that therapist becomes the one to make the decision for that client. If the therapist perceives himself/herself as an expert (having a great deal of knowledge and having worked with a great many clients involved in infidelity), that therapist may feel powerful and appoint himself/herself as the one who knows best what is good for those clients.

Raven (1993) revisits his earlier work (French & Raven, 1959; Raven, 1965) and proposes a new model for conceptualizing power as it plays out in interpersonal relationships, such as the one between client and therapist. He acknowledges, as he and his colleagues had done earlier, that six forms of power are at play during relationships. They are, specifically, (a) reward power; (b) coercive power; (c) legitimate power; (d) referent power; (e) informational power; and (f) expert power. Expert power may

exist as a result of the position members of the relationship hold within the stage of their association (e.g., teacher-student, therapist-client). When person B (the client in our scenario) perceives person A (the therapist) as having certain knowledge or skills that are necessary for person B to accomplish his/her goals, person B may subjugate his/her own decision-making power to "the expert" member of the relationship.

Informational power (Raven, 1992) is very similar to expert power. When this type of power is at play, if the client (person B) perceives the therapist (person A) as possessing information that he/she (client) sees relevant to himself/herself, he/she will attribute expert power to the therapist and once again might place himself/herself in the one-down position in the relationship (Brown, Pryzwansky, & Shulte, 1998).

It follows that at any given time during the therapeutic process of couples therapy, regardless of the presenting/evolving issue the client brings to therapy, he/she will attribute expert power to the therapist and will place some or all of his/her fate under that therapist's leadership, including his/her decision of whether or not to disclose his/her secret affair to his/her partner.

How does the therapist's professional experience in the area of working with clients involved in affairs affect his/her tendency to promote disclosure (exercise power) over the clients, especially his/her expert power over someone (client) who might be willing to submit?

Personal Experience and Family of Origin History with Infidelity (PEI & FOHI)

Glass and Wright (1988) take great care in pointing out that the empirical and clinical literatures are separate, and that each suffers from a bias attributable to which population is under observation. They underscore the importance of clinicians being able to recognize that affairs, or extramarital sex (EMS) or extramarital involvement (EMI),

as they call them, do take place in "normal" men and women, in stable marriages, and not just in people who suffer from interpersonal or relationship pathological processes.

Glass and Wright (1988) and others (Brown, 1989, 1991, 1999; Knapp, 1975) declare that clinicians lack consensus on ways to address the prevalent rate of affairs and that, frequently, they abandon an objective stance and project their own personal biases when their clients present with issues of extra-relationship behavior.

Knapp (1975) boldly reported that the attitudes of therapists towards affairs are directly related to their own affairs experiences. Specifically, she reported that almost one-third of the marital counselors she surveyed had more accepting attitudes towards their clients' affairs if they themselves had engaged in secret affairs. Those therapists with no personal history of affairs in their own lives tended to judge clients engaging in affairs as being neurotic, antisocial, or suffering from a personality disorder.

With regard to family-of-origin history with infidelity, rooted in the theoretical framework of Bowenian Theory (Bowen, 1978), Eaker-Weil and Winter (1994), Moultrup (1990), and Schnarch (1991) write of affairs as a family legacy handed down from one generation to the next. They connect the affair legacy to the Bowenian concept of the nuclear family emotional system, the concept of triangles as the emotional building blocks of and the stabilizing forces of families, and to the concept of the multigenerational transmission process that passes patterns from one generation to the next within the larger family system.

In this vein of thinking, it can be deduced that therapists bring to the therapy room their own inherited legacies from their own families of origin. The Bowenian framework is rooted in the psychodynamic philosophy of psychology. In the psychodynamic model, the idea that a therapist enters the therapy room with his/her own

agenda that may get in the way of the work to be done with clients was referred to as countertransference. If the therapist does indeed have unresolved issues with his/her inherited legacy around affairs, he/she might unknowingly project onto the client(s) his/her own unresolved past conflicts through the phenomenon of countertransference (Freud, 1933/1965). Slipp (1984) suggests that, in fact, a therapist will project onto the client(s) his/her own biases if unresolved conflicts do indeed exist within himself/herself; therefore, his/her own family of origin experience will play a part in the way he/she treats clients. In the Bowenian model, the legacy of affairs inherited by clinicians from their own family of origin and projected (countertransferred) onto the client would be analyzed from the perspective of the concept of differentiation.

According to Bowen (1978), differentiation is the degree of fusion or lack of individuation between emotional and intellectual functioning at both the intrapsychic and the interpersonal levels. People who tend to be "fused" are dominated by their automatic emotional system and/or by the pull they feel from the lack of emotional separation from their family system. If the therapist is not well differentiated from his/her family of origin, he/she may not be able to separate well his/her thoughts from his/her feelings, and might approach a client with automatic responses, and not with deliberate, rational interventions. Rational interventions occur best when a clinician is able to place his/her intellect over his/her feelings, to delineate his/her own feelings from his/her personal beliefs/preferences, and then to contain the feelings/preferences so that he/she can remain facilitative and not inappropriately directive or impulsive.

Brown (1991) suggests a list of behaviors that tend to indicate that a therapist has not separated his/her own issues from those of the clients. She also warns therapists that if they are treating many couples, and they are not seeing a high proportion of affairs

among their clients, perhaps the reason is that the therapist is obstructing the view. Specifically, she lists

- Colluding with one partner to keep the secret affair secret because the therapist wants to avoid the discomfort that comes with dealing with affairs.
- Being over-responsible towards the clients so to create unrealistic goals for the treatment—for example, wanting the issue resolved and the marriage rebuilt more than the clients do.
- Imposing moral (right/wrong, good/bad) instead of professional judgment while working with the couple.
- Being intolerant of one member of the triangle.
- Being fearful of intense feelings and muffling them in therapy sessions.
- Exhibiting more obligation towards marital/relationship fidelity than to the client.

She especially cautions those therapists who are ministers or pastoral counselors and who might have gone into the ministry as a means of helping themselves control their own issues of sexuality.

This study attempts to determine how clinicians' own personal and family history with infidelity influences their clinical actions and their tendency to promote disclosure when they are working with clients who are involved in affairs.

Need for the Study

The literature indicates that between 40% and 66% of men, and between 18% and 36% of women, become involved in affairs (Athanasiou, Shaver, & Travis, 1970; Hite, 1981; Kinsey, Pomeroy, & Martin, 1948; Kinsey et al., 1953; Pietropinto & Simenauer, 1976; Yablonsky, 1979).

In the clinical population, 25% to 30 % of couples arrive at therapy with infidelity as the presenting problem, while 30% to 35% more disclose a problem of infidelity during the course of therapy (Glass & Wright, 1997).

According to Weiner-Davis (1992), although infidelity leads to feelings of betrayal, mistrust, anger, and hurt, it does not necessarily have to lead to divorce. For the betraying partner, feelings of guilt over the pain he/she has caused can be too much to bear and he/she might decide to leave the marriage. Or, feelings of shame may be so deep that he/she decides to end his/her life.

The work of recovery is lengthy and requires much patience from both partners. (Humphrey, 1987). The recovery period can vary from 2 to many years and, for some, recovery is never attained, leaving them to live lives filled with disappointment and bitterness (Brown, 1991).

The disclosure or discovery of an affair invariably leads to a lengthy period of deep pain. The decision of whether or not to disclose should not be taken lightly and should never be made in haste. Clinicians need to be clear about what their policies on telling are.

The existence and subsequent discovery of infidelity in a marriage and/or in a committed relationship is a devastating occurrence. In a national study, Whisman, Dixon, and Johnson (1997) surveyed couples therapists (N = 122) regarding their perspectives on which problems present most frequently in therapy, which are most difficult to treat, and which create the most damaging impact on the clients' lives. They concluded that infidelity is the second most devastating problem to families (second to physical abuse) and the third most difficult to treat (behind detachment and dysfunctional communication).

Theorists such as Glass (2003b); Glass & Wright (1988, 1992) and Lusterman (1998) have determined that learning about a partner's affair creates a psychic injury that leads to an aftermath that includes the same effects and behaviors as those described in

the Statistical Manual of Mental Disorders (DSM-IV-R, American Psychiatric Association [APA], 1994) for the diagnosis of Post Traumatic Stress Disorder (PTSD). Stabilization and recuperation from the trauma can take a minimum of one year and possibly much longer (Brown, 1991). Lack of trust can remain an issue in the relationship for as long as three years and longer from the time of disclosure/discovery.

Based on observing his own clients, Pittman (1987) purports that 90% of divorces involve infidelity. R. Brown (1999) claims that 35% of couples recover from infidelity and continue their relationship. Through a multiple regression analysis, Stack (1980) found that in the 50 American states, the incidence of divorce is closely associated with the rate of suicide (while controlling for age, race, interstate migration, and income). He reports that a 1% increase in divorce is associated with a 0.54 % increase in the suicide rate. This finding supports other's opinions that divorce can be a devastating outcome of marital unhappiness (Ahrons, 1994; Wallerstein, Lewis, & Blakely, 2000). If the occurrence of divorce is associated with a higher rate of suicide, and if infidelity is present in 90% of divorces (as Pittman proposes), then it would follow that assisting people in keeping their relationships intact or in carefully planning the best clinical interventions for treating infidelity (ones that do not simply cause clients to run to divorce court) might be best at minimizing the damage done in the process of disclosure, especially at the hands of the therapist.

Patterns of infidelity become legacies that continue to create devastation from one generation to the next in family systems (Eaker-Weil & Winter, 1994; Moultrup, 1990). For those couples that prefer working through their difficulties to pursuing divorce, meeting up with well prepared, competent clinicians who are familiar with productive

interventions when working with infidelity will optimize the prospect of achieving their desire to stay together.

If what Pittman (1987) says about infidelity being present in 90% of divorcing couples approximates truth, and given that infidelity creates deep scars, then helping clients who go to therapy create a better marriage or a better divorce post-infidelity can yield a more favorable outcome for the couple, their children, their families, and society in general, and possibly reduce the number of suicides. The issue of secrets and confidentiality is especially relevant when the treatment unit consists of more than one person, as is the case with couples therapy. Clinicians are frequently faced with clinical dilemmas they must resolve as they attempt to help their clients during therapy (Scaturo, 2002).

When clinicians are faced with avoiding collusion with one member of the couple against the other; knowing information that, if disclosed, could hurt (emotionally or physically) one or both member(s) of that couple; or needing to share information in a conjoint session that was thought to be private by the member who disclosed it, a careful approach is essential.

Learning what other clinicians do, and how other clinicians handle the dynamic of disclosure, can be empowering to the clinician who is constructing his/her own careful approach to facilitate "telling."

Given the plethora of painful activity that can follow the discovery or disclosure of an affair, the questions remain:

- What are therapists' perspectives on the disclosure of affairs during couples therapy?
- What is happening in the therapy rooms regarding affairs disclosure?

- Who is deciding if the affair is to be disclosed—the client or the therapist—if it falls on the client to suffer the pain to do the reparation work?
- How is it currently being decided who, what, when, and how much is disclosed of the affair during couples therapy?
- What factors influence therapists' positions regarding the disclosure of affairs during couples therapy?

Purpose of the Study

The purpose of this investigation is to determine the actions clinicians take when they learn or suspect that a secret affair exists in the lives of the couples they treat or are about to treat, and how those clinicians' gender, and clinical/professional, personal, and family of origin experiences with infidelity, influence the actions they take. Three goals are conceptualized:

Goal 1

To develop a valid and reliable scale that measures a clinician's level of tendency to promote disclosure when faced with the suspicion or the knowledge of the existence of an affair in the relationship of couples in his/her care.

Goal 2

To identify and report those actions therapists and counselors take when faced with the suspicion or the knowledge of the existence of a secret affair in the relationship of couples whom those clinicians are treating, or are considering treating.

Goal 3

To analyze, determine, and report how a clinician's gender, and clinical/professional experience with infidelity (CEI), personal experience with infidelity (PEI); and family of origin history with infidelity (FOHI), influence his/her position on whether or not an affair must be unearthed or disclosed as part of couples therapy.

In addition to the above goals, it is the hope of this researcher/clinician that the following objectives also be accomplished as a by-product of this initiative:

- To expose clinicians to real-life scenarios that are part of the treatment of infidelity so that the scenarios will stimulate their thinking as they consider their actions when faced with each dilemma presented in the questionnaire.
- To encourage clinicians to think about whether or not they tend to come to their therapy rooms with unproductive biases and actions based on moralistic attitudes or rigid posturing.
- To disseminate the study's results into the public domain of the clinical community so that it might be used for treatment-planning, teaching, training, writing, personal development, and further research.
- To augment the academic dialogue that places infidelity on higher ground within the identified clinician training needs—and perhaps be seen as an issue with the same need for focus in couples work as domestic violence and substance abuse.
- To assist clinicians in entering their therapy rooms with less bias and judgmental attitude by beginning the cognitive restructuring process necessary to enable them to conceptualize infidelity (for clinical purposes) as a neutral phenomenon, socially constructed, and viewed in the context of the evolution of love and committed relationships over time.
- To identify research ideas for future studies on infidelity.

Promoting Disclosure

Although they may differ on the amount of information to be shared during disclosure/discovery of an extra-relationship affair, many clinicians recommend that secret affairs be brought to the surface during couples therapy (Brown, E., 1991, 1999; Glass, 2002, 2003b; Glass & Wright, 1988, 1997; Pittman, 1985, 1987). Young and Long (1998) believe that novice therapists make the mistake of keeping confidential the existence of an affair and therefore conduct therapy on a stage of deceit.

Some (Humphrey, 1987) propose that it is the client who should decide if an affair is to be disclosed because it is that client who takes the intrinsic risks of disclosure. He remains somewhat neutral on the subject because he also believes that clients have

the exclusive right to decide whether on not an affair is to be disclosed because the clients need to decide for themselves whether or not they are willing to do the intense and extensive work necessary to rebuild the relationship after the affair has been revealed.

Others (Moultrup, 1990) caution therapists not to be overly zealous so as to imbalance the triangle that the couple has created with the other man/woman and to be especially slow at promoting that the affair end immediately. He points out that the triangle has a function in the family and the marital relationship and that disrupting that balance too quickly can be detrimental to the family system of that couple.

Promoting that an affair be disclosed in therapy requires a clinician who is very clear on where he/she stands on whether telling/disclosing is a must. It requires a therapist to exercise a willingness to be active, assertive, directive, and somewhat authoritarian in his/her approach. In order to dictate what must happen, the clinician must be willing to exercise authority over his/her clients.

The notion of level of directiveness in promoting the telling of an affair was formulated from the concept of authoritarian behavior. The more authority a clinician exhibits, the more direct that clinician will be in his/her requests of the clients. When a clinicians insists on disclosure—he/she is directly requesting that the action be taken or a consequence will ensue (termination of conjoint therapy)—that clinician is showing a high tendency to promote disclosure.

Definition of Terms

Affair is a relationship that can be short-term or long-term and is defined by the presence of an emotional and/or physical attachment/behaviors between two people, one or both of whom are involved in an exclusive relationship with someone else. The affair relationship may include some or all of the following: secrecy; emotional intimacy;

sexual chemistry; flirtatious or passionate kissing; petting; sexual intercourse; anal sex; oral sex; mutual masturbation; masturbation using the affair partner for visual and/or in-person stimulation; or using pornographic materials, chat rooms, or exchanging erotic pictures of self, without the primary partner's knowledge or agreement/endorsement. The key to defining the relationship an affair is the fact that all or parts of the affair relationship remain a secret from the committed partner(s). The relationship is an affair if it violates the contract/agreement for exclusivity and openness of communication (truthfulness) made by the committed relationship partners to one another. Affairs may take place over the Internet, on the telephone, and in the workplace.

American Association of Marriage and Family Therapy (AAMFT) is the professional organization for Marriage and Family Therapists. AAMFT represents the interests of, and provides training for, it's clinical community (the members).

Couples therapy is the treatment of couples. It is used in two psychotherapeutic domains. It applies certain treatment methods to problems that are reliably seen as interactive and interpersonal. It is used also as a first-line treatment of choice for problems that have been traditionally seen as individual mental health issues. Couples therapy seeks to help couples resolve conflicts that involve deeply felt values in areas such as gender, religion, race, and ethnicity. It also seeks to help couples better negotiate their sex-role identity and culture identification issues as they emerge in the self and in their marital/committed relationship (Jacobson & Gurman, 1995).

CEI is an anachronism created here to represent the concept of Clinical/Professional Experience with Infidelity. In this investigation, it is one of the independent variables of the study and is derived from the responses to the corresponding questions on the demographic questionnaire in this study. The information it summarizes

pertains to a clinician's responses to the questionnaire vis-à-vis the types of clients he/she has worked with during his/her work with infidelity (the betraying partner, the betrayed partner, or the other man/the other woman).

Clinician/therapist/counselor are terms pertaining to members of the American Association of Marriage and Family Therapy (AAMFT). The terms are used interchangeably in this study.

Combination emotional-sexual affair is a secret, extramarital or extradyadic relationship that includes elements of both emotional and sexual affairs. It encompasses secrecy, intimacy, sexual chemistry, emotional attachment, caring (sharing life-events, exchanging family photos, and spending time nurturing each other), and sexual contact (kissing, petting, sexual intercourse, oral sex, and exchanging erotic pictures of self.).

Disclosing is bringing into the open something that is secret. The disclosure of a secret extra-dyadic affair involves addressing all relevant questions about the infidelity, setting limits that promote healthy functioning and minimize unhealthy behaviors (such as sleep deprivation), avoiding the escalation of destructive arguments that can lead to physical or verbal abuse, and minimizing the traumatic response in the partners (Glass, 2003b).

Emotional affair is a relationship that is primarily defined by the presence of an emotional attachment between two people, one or both of whom are involved in an exclusive relationship with someone else. The affair relationship includes secrecy, emotional intimacy, and sexual chemistry, but excludes contact and communication of a sexual/physical nature. The affair can take place in person, over the Internet, or on the telephone. Even when the relationship (friendship) is known to the excluded committed partner(s), some aspect of the "friendship" remains secret.

Family of origin refers to the family to which one is born or adopted.

FOHI is an anachronism created here to represent the concept of Family of Origin History with Infidelity. In this study, it is one of the independent variables and it summarizes the clinician's responses to whether he/she believes, suspects, or knows whether his/her female caregiver, and/or his/her male caregiver, and/or his/her maternal grandmother, and/or his/her paternal grandmother, and/or his/her maternal grandfather, and/or his/her paternal grandfather, was/has been a betraying partner, and/or a betrayed partner, and/or the other man/woman. FOHI was conceptualized using the family systems model of three generations—self, parents/caregivers, and grandparents (Sauber, L'Abale, & Weeks, 1985).

Gender (G) is one of the independent variables in this study, containing two levels, male and female.

Infidelity: Clinician Demographic Questionnaire (ICD-Q) is the questionnaire developed and used in this study that contains questions designed to collect demographic information about the participants, including the CEI, PEI, and FOHI scales.

Infidelity Perspective Survey (IPS) is the questionnaire developed and used in this study that contains the scale that measures a clinician's tendency to promote disclosure of affairs during couples therapy. The IPS includes 11 typical dilemmas encountered by therapists when they work with couples affected by affairs and also includes a set of personal belief systems particular to clinicians.

PEI is an anachronism created here to represent the concept of Personal Experience with Infidelity. In this investigation, PEI is one of the independent variables in the study and is derived from the responses to the corresponding questions on the ICD-Q. The information it summarizes pertains to a clinician's responses to the questionnaire

vis-à-vis if he/she or his/her partner is/are now or has/have been in the past a betraying partner, a betrayed partner, or the other man/the other woman.

Sexual affair is a relationship that is primarily of a sexual nature and that can take place in person, over the Internet, or on the telephone. It may be a short-term or a long-term secret relationship unknown to the excluded committed partner(s). It involves sexual behaviors, such as kissing, petting, sexual intercourse, oral sex, masturbation, exchanging of erotic pictures of self, and exchanging erotic stories, but *excludes* emotional attachment and caring.

Guiding Questions

The following guiding questions framed this study:

- Does the IPS validly and reliably measure therapists' and counselors' tendencies to promote the disclosure of affairs as part of couples therapy?
- In couples therapy, what is the effect of clinicians' gender (G) on their tendency to promote the disclosure of affairs
- In couples therapy, what is the effect of clinicians' clinical/professional experiences with infidelity (CEI) on their tendency to promote the disclosure of affairs?
- In couples therapy, what is the effect of clinicians' personal experiences with infidelity (PEI) on their tendency to promote the disclosure of affairs?
- In couples therapy, what is the effect of clinicians' family of origin experience with infidelity (FOHI) on their tendency to promote the disclosure of affairs?
- In couples therapy, what is/are the effect(s) of two-way interactions involving the combinations of gender and levels of CEI, PEI, and FOHI, on clinicians' tendencies to promote the disclosure of affairs?

Organization of the Rest of the Study

The rest of the study is contained within the next four chapters. Chapter 2 contains a review of the body of literature related to the issue of infidelity and disclosure. Chapter 3 presents the methodology that is used in the study, including the data collected

(expert opinion and pilot study) as part of the process that led to the main phase of this study. Chapter 4 contains the results of the main study, including the qualitative data obtained as part of the IPS completion. Chapter 5 includes the discussion, conclusion, and limitations of the study, as well as recommendations for further research.

CHAPTER 2
REVIEW OF RELATED LITERATURE

Introduction

To best understand the subject matter involved in the "disclosure of affairs" dynamic in the therapy room, affairs and infidelity must be considered in the context of the practice of psychotherapy in general and in the social context of the times. When clinicians enter their therapy rooms to treat clients, they bring with them all the elements that make them who they are and therefore many of the elements that influence the decisions they make in that room.

As clinicians are called upon by clients to provide specialized treatment, the clinicians must not only utilize the special knowledge they possess about the subject matter, the generic clinical skills they have integrated into their modus operandi, and the special skills required to handle the special problem, they must also call upon their understanding of the subject matter in the context of the bigger picture—the field of families and relationship science. Additionally, the clinicians must be cognizant of their own beliefs, biases, and moral standards, so that they can remain facilitative and not become shaming or controlling. This is especially important when the issue is a controversial one like infidelity.

Much has changed since the late 1800s and early 1900s, the days of Sigmund Freud and Carl Jung, when psychological and psychiatric intervention included only Psychoanalytic thought and practice (Campbell, 1971; Strachey, 1965), mostly in a male

dominated society in the back wards of mental institutions (Geller & Harris, 1994; Lamb, 1982).

Presently, both male and female clinicians have at their disposal a myriad of clinical models and a variety of approaches with which to practice their art. Sharing with each other what they do in their therapy rooms can serve as an empowering source of new learning for the whole clinical community. This chapter describes many of the facets of clinical practice in the work of navigating infidelity with the couples in therapy.

This literature review is divided into two parts that together create the foundation for what happens in the therapy room, each day, as the therapist makes important decisions while assisting his/her clients navigate their ship in the murky waters of the wake from infidelity and betrayal. Clinicians have a part in setting sail to that ship when they make the decision to promote the position that a secret affair must be disclosed during therapy, or else (Brown, E., 1991, 1999; Glass, 2003b; Lusterman, 1998; Moultrup, 1990; Pittman, 1989; and Schneider, 1988).

Part I of the literature review describes the context within which much treatment of infidelity occurs—couples. This part, entitled "Couples, Couples and Couples," includes seven subsections:

- Couples and Family Therapy in Social Context
- Transitioning from Modern to Post-Modern Thought
- Indications for Couples Therapy
- Contraindications for Couples Therapy
- Problems in Committed Relationships
- Characteristics of Healthy Couples
- Common Issues in Committed Relationships

Part II addresses the core of the information most closely pertaining to the subject matter in this study. Named " Love, Sex, and Betrayal," it includes 13 sections:

- Love and Exclusive Commitment, the Big Picture

- Monogamy in the Social Context
- Sex and Human Nature
- Religion, Christianity, and Sexuality
- Infidelity, Adultery and Other Names
- Prevalence Rates of Infidelity
- Attitudes and Gender--Differences Among People
- Theoretical Typologies and Patterns of Infidelity
  (divided into 11 subsections: Shirley Glass and Thomas Wright; Frank Pittman; Emily Brown; Sexual Addiction; David Moulthrop; Imago Relationship Therapy; Don-David Lusterman; Lana Staheli and Florence Kaslow; Eaker-Weil and Winter; Subotnik and Harris; Cyber-Infidelity; and Open Marriage and Swinging)
- Discovery and/or Disclosure
- Clinical Dilemmas in Treatment
- Dilemmas Encountered by Clinicians Working with Infidelity
- The Professional Community Speaks Directly on Infidelity Dilemmas
- A closing statement.

Part I: Couples, Couples, and Couples

Couples and Family Therapy in Social Context

What occurs in the therapy room is the synergistic culmination of many years of psychotherapeutic evolution that each clinician has internalized and utilizes. The therapeutic session leans on influences from the past, from the Modernism era, and from the more contemporary philosophy called Postmodernism.

Gergen (1991) describes the Modern period as a time when the self resided primarily in a person's ability to reason, to have beliefs and opinions, and to act on conscious intentions. The Modernists approach advocates for a stable family life, moral training, and a rational choice of marriage partner. Additionally, assumptions about reality include the idea that reality is certain, that it is true or false, and that creating change is a task done from outside of the problem.

The Postmodern movement proposes that the self is surrounded by many truths (Anderson, 1995) and that the truth is "made up" instead of "found." Reality is socially constructed within the four corners of society (the evolving self-concept, the moral and

ethical dialogue, the free-styles of art and culture, and the globalization of the world) through personal perceptions, language usage, and varied worldviews.

Therapy within the Postmodern approach is a collaborative process that includes the influence of the therapist's presence and the externalizing of problems as existing outside of the person, as a separate entity, and resolved through the accessing of personal power and innovations.

Common themes include diversity, inclusivity, collage, and choice. The issue of equitable power distribution is paramount (Foucault, 1991). This is especially important to the way gender roles play out in committed relationships. Morality and religion are important to the context of infidelity because, for many people, morality and religion guide their behaviors.

Transitioning from Modern to Postmodern Thought

As mentioned before, the Postmodern movement (Anderson, 1995; Foucault, 1991; Gergen, 1991) in society created a new way to conceptualize families—in the context of their culture and in the context of their unique experience.

The new ways of thinking change the perception of the self (as mates, as females) and the roles each self plays in life's tasks (Walters, Carter, Pap, & Silverstein, 1988). With regard to infidelity, as a woman achieved a more powerful status, her role as subservient (sexually) to males changed. Now, she could refuse sex, and perhaps even engage in extramarital sex and affairs in her own right, and maybe even enjoy the support of society.

Feminism (Haddock, Zimmerman, & MacPhee, 2000; Rampage, 1995) focused on the power differential of males and females and criticized many of the premises of family therapy for their male conceptualized and male dominated foundation. For

example, one major issue that emerged was the need to begin seeing families in their social-political context (Avis, 1988).

In the family therapy field (which includes couples), an emergence of interest and focus on power differentials caused by gender issues, ethnic/racial concerns, economic factors, and sexual identity, occurred (Carter & McGoldrick, 1999; McGoldrick & Preto, 1984).

In couples therapy, Boyd-Franklin (1989, 1993) and Boyd-Franklin and Franklin (1998) voiced the challenges encountered by Black couples. They emphasized the even more difficult challenges that African-American lesbian couples encounter as a result of being marginalized twice in society. . . once for being black and once for being gay. Without a new foundational worldview, the therapist may never be able to place infidelity in the larger context experienced by the couple.

Falicov (1988, 1995) shed new light on the traditional view of family triangles (Ackerman, 1966; Bowen, 1978; Haley, 1967, 1976; Minuchin, 1974) by proposing that—when revisioning family triangles, instead of having as a goal the American middle-class vision of the family where therapy focuses on restoring boundaries around the marital couple—the clinician take into account that families from other ethnicities, races, and social classes may benefit from using other family ties to help resolve the conflict. A clinician's focusing strictly on placing strong boundaries around a conflicted couple can block important participation by other family members that would enhance the resolution of the conflict. Clinicians should refrain from the temptation to indoctrinate ethnically diverse clients with the dogmas of the dominant white middle-class culture, including those pertaining to relationship infidelity (Falicov, 1998).

The topic of crimes against women was broached (Bograd, 1999; Goldner, 1999; Jacobson, 1999). The focus on domestic violence (physical abuse, sexual abuse) became central in the psychotherapy dialogue following a formal call to action by feminist clinicians (Avis, 1992; Erikson, 1992). Infidelity is at times a core advent in couples that engage in abusive and/or violent behaviors.

The advent of the depathologizing of homosexuality and other sexual identity issues (APA, 1994) rendered as "normal" or "acceptable" a great deal of what was once considered pathological, and the study of Gay and Lesbian Issues and Models for therapy emerged (Cass, 1979; Clunis & Green, 1988; Coleman, 1982; Levine & Troiden, 1986, 1988; Liddle, 1995). Sometimes, the extrarelationship affair is with a member of the same sex, or the primary relationship is a gay or lesbian one and the affair relationship is heterosexual. When infidelity is due to a sexual addiction, preparing clients to enter recovery requires their willingness and commitment (Miller & Rollnick, 1991).

New models with a positive focus have been developed. Walsh (1993, 1998, 2003) brought to bare the importance of family strengths and resilience. Walsh (1993) underscores the anxious effects that come from the tension between the idealized expectations in our culture and the actual experience of contemporary family life. New perspectives that can replace the old ideas of what is normal must include the demystification of myths such as the belief that there is one proper gender role, and the belief that the melting pot is equitable for both the white dominant culture and minority cultures. Perhaps, if expectations were different, some of the stressors that contribute to the high rate of infidelity would be reduced, resulting in a lower rate of infidelity incidence, and, perhaps, a lower rate of divorce (Pittman, 1989).

Walters, Carter, Pap, and Silverstein (1988) attempted to inspire women to access their ability to redefine their roles and to access their very unique abilities to recreate their world within the family and within the larger social context, including ways that involve their sexuality.

When couples divorce, and many do following the disclosure of an affair, children's lives change drastically. Braver and Griffin (2000) note the importance of engaging fathers in the post-divorce family. Marsiglio, Day and Lamb (2000) explore the diversity of thought involved in researching and creating proper ways to involve fathers in the postmodern family.

Waters and Lawrence (1993) incorporate the use of competence and courage in their model for therapy. They note that family therapists have been better at mocking the medical model than they have been at replacing it. Echevarria-Doan (2001) has proposed a Resource-based Reflective Consultation model that assists therapists to help their clients access their own resources and strengths.

A new phenomenon has been infiltrating family life. The invention of the Internet, cell phones, and digital technology has created new challenges for therapists as they conduct therapy. Many affairs take place over the Internet, and, because they do not meet the "traditional" criteria for an affair, are frequently minimized with regard to their significance and impact on the marriage (Neuman, 2001). New models are underway and many books have been published as theoretical frameworks for dealing with this issue (Collins, 1999, Maheu, 2003; Neuman, 2001; Schneider, 2000; Young, Griffin-Shelley, Cooper, O'Mara, & Buchanan, 2000).

The crisis of infidelity can create a need for the exploration of spiritual issues in therapy. It is an individualized process for each client, with unique forms of

understanding and practices. It is incumbent on the therapist to prepare himself/herself to meet whatever challenges the client brings to therapy, without imposing undue moral, spiritual, or religious doctrine on the client. When the therapist insists on the disclosure of an affair, he/she must be prepared to help the clients manage the aftermath of disclosure. Pastors, Christian Counselors, Rabbis, and other clerics must be made especially aware.

Issues of spirituality and religiosity emerge in therapy on a frequent basis. Clients present at therapy conflicted by their beliefs vis-à-vis their lifestyles, and may live in a constant state of guilt and dis-equilibrium. This is especially true when secret affairs are ongoing, so that life consists of many lies.

The counseling relationship can be a crucible for the creation and enhancement of spiritual awareness in clients (Hendrix, 19898; Schnarch, 1995, 1997). Several theorists (Frame, 2000; Hodge, 2000; Patterson, Hayworth, & Turner, 2000) have emphasized the importance of therapists understanding their own spirituality as a means of understanding spirituality in diverse forms in clients, and as a means of more holistically responding to what clients want and need in counseling, including the exploration of spiritual issues.

Traditionally, therapists are trained to clarify their own values, biases, and perspectives on life, and to develop a theoretical framework from which to draw as they practice. This is especially true as therapists help clients navigate the murky waters of the aftermath of betrayal. It is especially important for therapists to be clear as to where their space ends and the client's begins, and for therapists to commit to ongoing personal development designed to help them stay ahead of their clients as a way of remaining facilitative to the clients' growth. All this is with the goal of serving clients well and meeting them where they are, in their own life's context, within the realm of their

individualized social, psychological and intellectual needs, including those related to their spiritual and religious beliefs.

Calling on one's spirituality is especially important for some whose coping mechanisms during a time of extreme trauma or stress (as in the crisis of infidelity) are weakened. Even therapists who are not trained in religious dogma must be prepared to give spiritual support to clients whose hearts are so broken (as is often the case with betrayal) that their ability to think clearly is suspended.

Indications for Couples Therapy

That professional approaches, beliefs, and social contexts change as they evolve over time has been established in the previous sections. Alan Gurman and Neil Jacobson (1995) write that one of the most notable changes in relationship therapy is the supplanting of the word "marriage" with one that is more universal and less value-laden as a descriptor for committed relationships—"couples."

Beavers (1985) made a case for couples therapy as it began to evolve in the context of family systems therapy. Beavers suggested that couples therapy is especially indicated when, in a family, the couple (a) requests couples therapy, (b) neither member of the couple is psychotic or severely depressed, (c) both members of the couple wish for the relationship to continue, (d) individual psychotherapy reaches an impasse, and (e) when, in the therapy room, issues related to individual client's relationship with his/her partner consistently appears within his/her individual therapy session (that individual's projection of power, control and responsibility for problems on the spouse) and should be directly addressed with the spouse's collaboration.

Contraindications for Couples Therapy

The criterion for when couples therapy is indicated has both remained the same and changed over time—depending on the model of intervention preferred by the therapist. For example, Harville Hendrix (1988), in his Imago Relationship Therapy Model (IRT), suggests the suspension of decisions by couples regarding divorce or separation until the couple has undergone 12 sessions of therapy. The processes experienced during the sessions will clarify whether a commitment to the relationship journey is still possible for that couple after each member considers closing the exits that sabotage the achievement of intimacy and joyful living. An affair is one such exit according to IRT.

On the other hand, some therapists caution that unless both spouses are committed to the relationship and its well-being, conjoint couples therapy may be ineffective (Greenspun, 2000). When couples are divorcing, or when one member of the couple is coming out as gay or lesbian, they sometimes seek couples therapy. In this context, it is especially important to establish clear goals for the therapy that reflect the wishes of both members of the couple. Conjoint therapy might not be appropriate.

Some possible contraindications to couples therapy (conjoint or otherwise) include the presence of domestic violence or substance abuse, or the existence of a secret affair. Therapists should be very clear about their policies for approaching therapy in therapeutic circumstances that can present danger to one or both partners. Greenspun (2000) proposes that conjoint therapy with couples that engage in violence should be considered only if and when the abuser (usually the man) takes full responsibility for his violence, for his capacity to tolerate hearing the woman's description of being victimized by him, and for his willingness to work towards stopping his abusive behavior. This

must take precedence over any other intervention in couples therapy—including the disclosure of an affair.

Feminist therapist Bograd (1992) challenges family therapists to approach the issue of violence in a more rigorous manner during therapy. Bograd and Mederos (1999) proposed a comprehensive model for screening couples for the purpose of determining the appropriateness of conjoint therapy if violence is present.

A clinician's professional orientation influences couples work. It is important to remember that no theoretical model should ever supersede sound, clinical intuition and judgment. The dilemma that clinicians must resolve here is whether or not it is safe to facilitate the disclosure or the unearthing of a secret affair in a relationship that is or can become dangerous—especially if the betrayer is the possible victim of the danger.

Problems in the Couples/Committed Relationship Paradigm

Committed relationships can be challenging and often difficult to manage. Couples therapists must be aware of and prepared to treat the many presenting problems that coexist with infidelity and may be brought by couples to therapy. Young and Long (1998) claim that one in seven marriages are considered unhappy.

Divorce plagues the American family (Gottman, 1994a, 1999a; Wallerstein, Lewis, & Blakeslee, 2000; Young & Long, 1998). Half of all marriages end up in divorce, which typically is the result of a relationship laden with conflict. Some theorists claim that infidelity is the leading cause of divorce (Gottman, 1994b; Pittman, 1987).

Given the bleak picture of committed relationships, the evaluation and treatment of marital/committed relationship conflict is an essential skill for therapists to master (Guerin, Fay, Burden, & Kautto, 1987). When assessing couples for treatment planning,

Young and Long (1998) suggest that it be done on an ongoing basis and that, perhaps, the idea that assessment and treatment are intertwined should be remembered.

In the assessment process, some clinicians believe the individuals must be assessed first to assure that conjoint therapy is indicated (Bograd, 1992; Bograd & Mederos, 1999; Rosenbaum & O'Leary, 1986), while others encourage seeing couples conjointly exclusively (Hendrix, 1988).

Next, the therapist should focus on the problems with the relationships. There are many ways to accomplish this, with or without formal, structured measuring instruments (Christiansen, Jacobson, & Babcock, 1995; Gottman, 1976, 1979, 1999b; Hendrix, 1988; Jacobson, 1977; Jacobson & Christiansen, 1996; Straus, 1979).

One of the most widely used tools is the marital satisfaction inventory (Spanier & Lewis, 1980). Fredman and Sherman (1987) published a book on assessment tools for couples and families. During a crisis, the focus of assessment should remain on safety and the interventions on safety measures (Bograd & Mederos, 1999). Genograms may be used as an assessment tool to place the couple in its family system context (McGoldrick & Gerson, 1985; McGoldrick, Gerson & Shellenberger, 1999).

John Gottman (1979, 1980, 1993a, 1993b, 1994a, 1994b, 1999b, 2001) has been working with couples for many years. In his research, he has been able to predict divorce with an accuracy rate of 97%. His concept of the "Four Horsemen of the Apocalypse of Marriage" (criticism, defensiveness, contempt, and stonewalling [1999, pp. 41-47]) can be helpful in designing interventions with couples. The "Sound Marital House" therapy model (Gottman, 1999a) is his effort that specifically targets these relationships dynamics. He has also produced a self-help workshop that couples can buy and self-administer (Gottman, 2001).

Characteristics of Healthy Couples

According to Olson (1993), healthy, strong, resilient couples, like families, are those who achieve a balance among proper levels of cohesion (emotional bonding, boundaries, coalitions, time, space, friends, decision-making, interests, and recreation), flexibility (equitable control, negotiation, roles, and rules), and communication (listening, speaking, self-disclosure, clarity, respect, and regard). When couples find themselves out of balance in any or all of the three dimensions, they experience stress and dissatisfaction. They sometimes turn to people outside their marriage relationship for comfort and validation.

Wallerstein and Blakeslee (1995), with the intent of learning what is meant by a "happy" marriage/relationship, conducted a study of couples. They categorized their information within four patterns of marriage (romantic, rescue, companionate, and traditional). They discovered that strong, happy, resilient couples are those that successfully negotiate the nine marriage tasks (separating from family of origin, building together and creating autonomy, becoming parents, coping with crisis, making a safe place for conflict, exploring sexual love and intimacy, sharing laughter and keeping interest alive, providing emotional nurturance, and preserving double vision) while holding on to me.

In a comprehensive review article of the last decade of empirical research on marital satisfaction, Bradbury, Finchham, and Beach (2000) conclude that the literature on the subject shows enhanced understanding of couples vis-à-vis the complex environments they must adapt to.

The focus of their review includes studies that emphasize the understanding of (a) interpersonal processes that operate in marriage (cognition, affect, physiology,

behavioral patterns, social support, and violence; (b) marital satisfaction as a function of the milieus of which the couple are part (presence of children, life stressors, transitions, economic factors, and perceived mate availability); and (c) ways to conceptualize and measure marital satisfaction (measuring instruments and self-reports).

Gurman and Jacobson (1995) first declared, and now Johnson and Lebow (2000) declare, that couples therapy has finally "come of age." In their review of the marriage and family therapy research over the last 10 years, Johnson and Lebow (2000) establish the premise that, through couples therapy, distressed, at-risk-for-divorce couples can be redirected towards wholeness again by enhancing healthy emotional engagement and connection, enhancing gender equity, and minimizing inhibiting factors.

As the authors review the efficacy of couples therapy, they examine closely Gottman's work (1994a) and report his findings related to negative emotions and the way they interface with the presence of criticism, contempt, distancing, and stonewalling in relationships. When these behaviors become pervasive in a relationship, emotional engagement (an essential component of healthy, strong, resilient relationships) becomes impossible. In examining Beavers and Hampson's work (1993), the authors point out the importance of therapy's fostering responsiveness, fruitful negotiation, and skills for dealing with conflict.

The groundbreaking work of Jacobson (1985) has brought attention to the importance of including as essential outcomes in research and therapy not only *statistical significance* but *clinical meaningfulness*. For therapy to be effective, it must move clients into the satisfied, healthy range of functioning.

Imago Relationship Therapy (IRT) (Hendrix, 1988, 1992) offers a comprehensive model for addressing relationship needs in couples. Despite the maturation of this model,

little research has been undertaken to determine its efficacy. The primary goals of the therapy include assisting couples to achieve relaxed joyfulness through the healing of childhood wounds that tend to play a key part in mate selection and that tend to show up in a disguised form in the conflict couples experience during the power struggle of the relationship.

Patricia Love (2001) proposed 12 steps within four stages (infatuation, post-rapture, discovery, and connection) to making love last forever. She cautions couples to recognize that relationships are evolutionary and that couples must be willing to go on the journey from beginning to end. By first feeling the attraction, then settling into the more mundane, spending time gathering information about each other, clarifying roles, defining love, building trust, expanding commitment, deepening connection, forging friendship, creating a haven, providing support, and, finally, claiming love, will assure a happy, satisfying couplehood and the minimization of psychological pain.

Many types of marriages/relationship have been identified. Schnarch (1997, 2002) promotes the concept of the passionate marriage. To achieve passion and true intimacy, couples must work on differentiating from each other.

Schnarch (1997) suggests accomplishing differientation through five activities. Each member must work at

- maintaining a clear sense of who he/she is as intimacy increased
- maintaining a sense of perspective about anxieties and other shortcomings about each other
- keeping alive the willingness to engage in self-confrontation to maximize growth
- remaining intellectually honest about one's own projections and distortions and especially being willing to admit being wrong
- recognizing and accepting that pain must be tolerated in order for growing to occur. (p. 324);

Other typologies for relationships also inform the way therapists conceptualize committed partnerships. Schwartz (1994) promotes the idea of peer marriage and the importance of equality in love. Thoele (1996) uses a transpersonal model for relationships in her focus of spirituality in marriage, as she promotes the creation of the heart-centered marriage.

Although not considered a scholar, John Gray (1992) has proposed that men and women can get along best if they recognize that they are as different as two different planets (Mars and Venus), and that, as such, they must work on adapting to each other's cultures and on learning each other's language and worldviews.

Common Issues in Marital/Couples/Committed Relationships Therapy

In couples therapy, many issues emerge that interfere with the achievement of healthy committed relationships. Some of the most prominent issues are those related to psychiatric disorders in one or both spouses (Jacobson & Gurman, 1995a). For example, when alcohol problems are present in one or both spouses, the relationship can become focused on the addiction (McCrady & Epstein, 1995). The couple's therapy must focus on the teaching of individual coping skills, on the behaviors of the nonalcoholic partner, on the interactions between the partners, on the management of the social system outside the relationship, and, finally, on the teaching of techniques that can help generalize to the natural environment and that will help maintain the new behaviors. Once the addiction is under control, the couple can begin working on the other issues in their relationship. Substance use and abuse has been linked to higher prevalence rates of infidelity, marital and family violence, and divorce.

The assessment and treatment of marital violence presents with some very special concerns, not the least of which is whether to see couples in conjoint therapy or each

member of the couple individually (Avis, 1992; Bograd, 1992, 1999; Bograd & Mederos, 1999; Holzwoth-Munroe, Beaty, & Anglin, 1995; Jacobson & Gottman, 1998; Stith & Straus, 1995).

The existence of undisclosed violence can place partners at a higher risk if personal disclosures occur in the therapy room. A batterer can be angered during therapy and then act out his/her anger later at home when the victim is vulnerable and unprotected. The therapist must remain cognizant of this covert risk and take appropriate steps to assure the safety of all clients.

Violence (emotional and physical) in couples can increase when the disclosure or the discovery of an affair/extra-dyadic sex comes to light (Brown, E., 1999). In this case, the therapist must be prepared to first protect and to then stabilize the situation, and finally must realign the therapeutic approach with the facts at hand.

Other psychiatric disorders that can be present in couples work are anxiety disorders (Craske & Zoeller, 1995); depression (Gotlib & Beach, 1995); eating disorders (Root, 1995), personality disorders (Slipp, 1995) and sexual disorders (Heiman, Epps, & Ellis, 1995). Grief reactions resulting form loss and other addictions, such as gambling or overspending, can create havoc in a relationship.

Although, theoretically, divorce ends the existence of the marital dyad in a family, couples frequently remain connected through conflict, which is then displaced and projected on the children (Ahrons, 1994). In relationship therapy, saying goodbye (Hendrix, 1988) in a friendly manner that achieves closure can facilitate a quicker stabilization of the family, post-divorce (Ahrons, 1994).

When infidelity is the catalyst for divorce, anger and resentment can linger on for years. Therapists must be sure to assess for any unresolved emotional turmoil that is due

to lack of closure from life's past events. Helping couples create a good divorce can make a huge difference in their quality of life postdivorce and can help create a happier environment for the children.

Walsh, Jacob, and Simons (1995) encourage a developmental model that begins with the evolution of the decision to divorce and proceeds to the management of the emotional turmoil in the immediate aftermath, the realigning with families and social support systems, the adjustment of new parenting roles, the adjustment to the resulting economic distress, and the disruption of the physical and structural dislocation. Eventually, issues of remarriage and step parenting emerge and must be dealt with (Visher & Visher, 1993).

Kaslow (1984) noted that each member of the couple (and the children, too) will, at his/her pace, go through the process of denial, anger, depression, and, finally, acceptance, within a two to three year period. The couple will experience feelings, behaviors, and thoughts, through three phases—predivorce decision making, divorce restructuring, and postdivorce recovery.

Kaslow and Swartz (1987) propose a dialectic model of divorce that comprehensively lays out feelings, actions, tasks, and therapeutic interventions that correspond to each of the three stages. Mediation can be used to assist couples through a more peaceful divorce (Neuman, 1989).

Although the political and social climate couples exist in is quickly changing, gay and lesbian couples still face special issues when separating because of the lack of legal status in most of the gay and lesbian relationships. Laird (1993), Sanders (2000), and Marvin and Miller (2000) point out that gays and lesbians face the issues of losing

children that are not biologically related to them. In couples therapy, gay and lesbian couples face many challenges that heterosexual couples do not.

Medical conditions can also create the need for specialized therapy. Issues of death and dying have contributed greatly to the emergence of spirituality counseling. Spirituality counselors aim to mitigate the transpersonal and the personal.

Rapoport and Rapoport (1971) describe the dual-career couple. Stoltz-Loike (1992) underscores that this type of couple has become the dominant lifestyle in America. The dual-career couple has many external stressors that place a burden on the relationship. Sometimes the members escape into an extramarital affair.

Until 1967, it was illegal in some states for interracial couples to marry. Intermarriage refers to a committed relationship that includes the added dimensions of one partner's racial, cultural, and/or religious background as different from his or her own.

Ho (1990) suggests that intermarriages are like any other union and that although they may enjoy the added advantages of greater vitality in family living due to the diversity in the family, the barriers are many at the ecological level and at the spousal interaction level.

According to Ho (1990), the ecological barriers that can add much conflict to the lives of intermarried include racism, prejudice, discrimination, social class, immigration and cultural adjustment, language and physical diversity, extended family problems, and greater difficulty at adjusting to family life cycles.

Within the realm of spousal interaction, arguments may arise out of conflict due to food and dining etiquette, festivities and observances, friendships and social network, financial management, religion, sexual adjustment, childrearing practices, and gender

role expectations. Identifying the couples' values regarding marital fidelity is essential for best therapeutic outcomes.

Sexually Transmitted Infections (STI), especially HIV and AIDS, have created a new awareness in the area of sexuality counseling. Couples who must contend with infectious disorders require a great deal of psycho-education as part of their therapy (Rathus, Nevid, & Fichner-Rathus, 2000). The issue of STIs is a special topic of focus in couples and individuals who are working through the effects of an affair and/or betrayal. Many spouses learn of his/her partner's infidelity when they themselves are diagnosed with an STI.

Irrespective of the presenting issues by couples, the typical interventions include the teaching of combinations of several of the following skills: communication, conflict-resolution, self and couple assessment, understanding family of origin, negotiation, role-playing, behavioral contracts, modeling, paradoxes, giving information, spiritual reflection, group process, behavioral rehearsals, fun enhancement, mentoring, restructuring expectations, problem-solving, self-instructions, behavioral tasks, and giving and receiving nurturing. The therapists or facilitators include both professional therapists/clinicians and para-professionals.

Many models exist that are designed for the treatment of relationship dysfunction. Dattilio and Bevilacqua (2000), Jacobson and Gurman (1995a), and Gurman and Jacobson (2002) have assembled three books that include the major theoretical framework for couple's therapy.

The prolific work of John Gottman has become a staple in marriage counseling classes. His model of the Marriage Clinic (1999a) has been packaged not only for clinicians, but for the community at large. The Acceptance and Change in Couple

Therapy (Jacobson & Christiansen, 1996) has provided an integrated model that is applicable and useful in many circumstances.

Whatever model of therapy a clinician adopts, the desired outcomes remain the same: marital/relationship happiness and good quality of life that includes emotional, physical and spiritual connection.

Part II: Love, Sex, and Betrayal

Love and Exclusive Commitment: The Big Picture

A relationship model that includes romantic love, sex, affection, friendship, and family roles, all in one single relationship, is a relatively new phenomenon. A glimpse at the evolution of love and sex throughout time provides a useful perspective for present views on love, sex, exclusive commitment, and monogamy in relationships.

Taylor (1970) describes the evolution of man-woman relationships over a 3200-year span. His work, similar to that of the social constructivists (Anderson, 1995; Dickens & Fontana, 1994; Gergen, 1991, 1994), underscores the idea that reality is contextually created and that humans must be understood in light of the times they live in, and in light of their experiences, values, attitudes, worldviews, and culture.

The History of Love (www.noe-tech.com/pleasures/history.html, 2004) summarizes the evolution of love in the following way. In the Grecian Era, we discover that, in Ancient Greece (450 BC - 1300 AD), a sexual double standard existed between men and women. Women were expected to remain virtuous while men were free to enjoy sex. In the Golden Age of Greece (450 BC - 27 BC), high-class prostitutes were considered superior to wives and to other virtuous women. Men expected faithful love from their women—but earned it through gifts and tricks. Men in love were considered ill. Love was not connected to marriage.

In the Roman Empire (27 BC - 385 AD), love was lusty, guilt-free, deceitful, and unfaithful. In 2 BC, Ovid wrote a manual for sex and adultery that contained items such as descriptions of sexual positions and how to achieve mutual orgasm. During the decline of the Roman Empire, as Christianity was emerging, all evils were linked to sex and pleasure.

In the Dark Ages (385 AD - 1000 AD), Christians promoted sex as a guilty and sinful act. Eroticism increased as sex became more forbidden. In the fifth century, marriage came under clerical domination and sex was viewed as unromantic, harsh, ugly, and punishable. Women became sexual property of men. Christian marital sex was performed only in one position and never during holy days. Sex without values (prostitutes, orgy, rape, or sadistic) was not a serious offense. Sex with value (loving or valuing a woman) was a high sin.

Courtly love arrived in the pre-Renaissance era (1000 - 1300), when the romantic ideal began to emerge. Courtly love was a clandestine, bittersweet relationship that, although spiritually uplifting, was highly frustrating because it was unrequited. Courtly love also introduced the elements of an emotional relationship between men and women for the first time (primarily in the noble class).

The Renaissance period reintroduced physical love into the culture. Women were viewed as "evil" if they engaged in sex. Love and marriage were combined for the first time when Henry VIII married Anne Boleyn. Mind and body began to be associated. The middle class began associating sex and love in the same way that the upper class had been doing.

In the Puritan period (1500-1700), two factions of society existed. Those following Martin Luther underscored the value-oriented meaning of love, sex, and

romance, while those following John Calvin could not dance, or wear jewelry or fancy clothes. Adultery carried the death penalty. Legitimate love was regulated and was intended only for reproduction and to eliminate incontinence.

The Age of Reason (1700-1800) brought a de-emphasis of sex; women of intellect were pursued. Men were deemed Don Juans (wanting to make sexual conquests) who used love to seduce women. The culture of the Victorian period (1800-1900) required women to be shy and virginal. Women had to be morally spotless and, at the same time, a love partner for their husbands and not just "housemaids." The Surgeon General declared that decent women should feel no pleasure during intercourse and that, if she did, she was pathological and at risk for sterility. This period resulted in much fantasy about sex (the popularity of prostitution and pornography rose dramatically).

The emancipation of women began during the Capitalism era (1850-1900). As the 20th century emerged (1900-1930), so did the idea that romantic love was the basis for choosing a life-long partner. The sexual desires of both partners could be satisfied. Lovemaking was separated from procreation, and the sexual revolution began.

The Modern and Postmodern periods (1930-2004) brought the concept of open marriages, progressive polygamy and sexual enjoyment. Psychological aspects of self (esteem and happiness) were (and are) acknowledged to be important to quality of life. Today, romantic love is part of everyone's goal. Its value is that it fulfills emotional needs and promotes happiness.

Monogamy in Social Context

Sociologist Sanderson (2001) explores monogamy and polygamy within the context of Evolutionary Psychology. He proposes that polygamy results primarily from male rather than female choice, as suggested by Kanazawa and Still (1999), because it

flows out of the male sexual desire for variety. Monogamy, on the other hand, is imposed by nations on their men in order to equalize reproductive opportunities. He describes women from poor areas as more likely to choose polygamy because poor women would rather be the last wife of a rich man than the only wife of a poor man.

Sanders (2001) presents a study conducted by Murdock and White (1969) and later examined by White (1981), which studied 186 societies in the Ethnographic Atlas (Murdock, 1967) using a cross-cultural sample. He reported that between 20% and 49% of males in the sample were polygamously married in 32% of societies, and half or more of the male population was involved in polygamous marriages in 9% of the societies under review. He applied a five-point scale (monogamy prescribed, monogamy preferred but some polygamy, polygamy preferred by leaders, polygamy preferred by men of wealth and rank, and polygamy preferred and attained by most men) to find that polygamy was moderately correlated with the contribution made by women to agriculture. He concluded that men are more motivated toward polygamous marriages when women's economic value is high and that men in all societies desire sexual variety and will take advantage of opportunities for it when they present themselves.

Sex and Human Nature

Barash and Lipton (2001), a zoologist and a psychiatrist, teamed up to examine at length the concept of monogamy. They note that within the natural universe, there is powerful evidence that human beings are not "naturally" monogamous. Whether humans should be monogamous is not their pursuit, but they caution their readers that monogamy is unusual and difficult despite the fact that humans *can* be monogamous. They acknowledge that for many people, monogamy is synonymous with morality and that for many, even desire-at-a-glance is considered a sin. They offer the idea that social

monogamy (learned through training) is different than genetic monogamy (which is more natural).

Many theories of sex exist (Karlem, 1971). May (1988) proposes that sex manifests itself in our lives through four theories that are concurrent, conflicting, and mischievous in all of us. He states that we view sex as demonic, divine, casual, or nuisance, and that each of these theories has its roots in a different cultural tradition and context. He suggests that the demonic theory is rooted in the Victorian era, the divine in the Romantic era, and the casual in the Liberal era, and that the nuisance theory is part of the British/Satirist tradition of formality. He concludes that consciously acknowledging this reality will enable us to better enjoy and participate in sexual pleasure.

LeVay (1994) believes that there are two contrasting ideas regarding sex. The first holds that all people are born with very similar brains and that everything (sexual lives, inner desires, inhibitions, fulfillment, and external life of sexual and reproductive activity) is shaped by the environment. The second declares that each person's brain is preprogrammed to function in a certain way—male or female, gay or straight, promiscuous or celibate—and that these characteristics will emerge without regard to environment.

Religion, Christianity and Sexuality

Exploring human sexuality within the context of religion can shed light on the positions clinicians trained in various areas of pastoral/religious counseling take in their therapy rooms. Some clients prefer a therapist who shares their religious worldviews and guides them accordingly.

Balswick and Balswick (1999) present the idea of authentic-human-sexuality. By this, they propose that Christians should consider living an authentic life that includes a

commitment to God and to clean living. Homosexuality is suspect for people of God. Sexuality is seen as a gift from God that should be expressed in the context of spirituality. Balswick and Balswick propose that human sexuality has many facets existing as a result of biological and socio-cultural contributors, and that human sexuality has four dimensions: natal sex, identity, gender role, and sexual orientation.

In theology, sexual relationships can exist only within commitment, grace, and the desire to serve and be served. Despite the fact that the four dimensions of human sexuality are innate and natural, any sexual expression that violates these boundaries is, according to the mandates of churches, sinful.

Historically, churches have tried to channel sexuality towards heterosexual marriage or celibacy, and have banned all other forms of sexual expression. This can have very serious ramifications to couples that are sexually unconventional.

Ellingson, Tebbe, Van Haitsma, and Laumann (2002) conducted a study that analyzed religion vis-à-vis the politics of sexuality. They used data from open-ended interviews with religious leaders and other area residents in three Chicago neighborhoods to determine how sexual norms and practices tend to shape the way congregations respond to sexuality issues.

According to Ellingson et al. (2002), the challenges faced by most churches are two: effectively responding to environmental trends and successfully integrating the members of the congregation. The constraints that churches face include the canons of beliefs and practices that they must follow, and responding effectively and efficiently to the dynamics of the neighborhoods they serve, especially to the sexual culture of their constituents. Many churches, such as the Roman Catholic Church and most of the Protestant denominations, have specific prescriptions that must be advanced. When this

is the case, a therapist whose training includes these rules will more than likely try to integrate them into his/her approach to his/her work.

The key informants who were most tentative with their responses in this study were the African-American clergy and members of the gay and lesbian communities, who feared political fallout. Interestingly, the authors conclude that religious leaders address sexuality issues more as a reaction to local culture, composition of membership pools, and identity of their mission, and less on policy, doctrine, and theological orientation. This is good news for those clients who wish to retain their connection to their places of worship and yet lead a life that might not be congruent with all of its teaching.

It appears that church leaders negotiate among the many constraints they face and control, accommodate, and tolerate. This has many implications for clinicians who are trained in the context of religious dogmas, and lends credence to the idea that pastoral counselors must use their clinical and spiritual judgment when counseling their clients and not simply the dogmas they study.

Scholars are working toward improving the way religion responds to human needs. Steensland et al. (2000) ambitiously embarked on the task of measuring American religion. They recognize that Americans are more religious than other citizens in most other industrialized countries.

According to the authors, religious worldviews shape social and political attitudes more than social class, educational achievement, and other sociological factors. This notion has great implication for counseling, especially in the area of sexuality counseling, gender identity, and extramarital sex. Slowinski (2002) urges therapists to develop a willingness to interface religious issues (conscience, sexual scripts, worldview, moral

values, the role of scriptures, and religious tradition) in the therapy room. Gamson (2001) cautions against embracing sex scandals within institutions as "normal sins." His concern is that normalizing sexual scandals will create new, acceptable social norms that have the potential to normalize antisocial behaviors.

The work of Thomas Moore (1990), a former Roman Catholic monk, advances Carl Jung's and Robert Bly's philosophy of the human shadow and the dark side of (wo)man. Moore's work points out the dichotomy of human nature—the Libertine (wild/evil) side and the Justine (pure/angelic) side, and their role in sexual dynamics.

The perspective one brings to the table will determine the approach one takes when evaluating the quality of his/her conduct, morals, and ideas. As counselors and therapists, the perspective one embraces strongly influences the types of interventions one employs with clients. Knowing one's own convictions and biases about religion, as well as other aspects of the human condition vis-à-vis one's own existence and the existence of others, can make one a more effective therapist. Knowing how one's gender and one's professional and personal experiences with infidelity impact the work he/she does, can assist the clinician to be more cautious and honest with himself/herself and with the client(s).

Infidelity, Adultery, and Other Names

Thompson (1983), in his review of the literature on extramarital sex, clarifies the difference between infidelity and adultery. *Adultery* is a legal term that is appropriate in referring to sexual relations with anyone other than one's spouse. *Infidelity*, on the other hand, is the violation of a promise or vow. Thompson cites Bernard (1974) as pointing out that, in the strictest sense, infidelity occurs not only when extra marital sexual relations occur but when one or both spouses cease to love, honor, cherish, or comfort

one another. This is an interesting idea and gives credence to some of the theoretical models that view infidelity as resulting from the collective interactions between both spouses (Beavers, 1985; Cashdan, 1988; Hendrix, 1988; Wallerstein & Blakeslee, 1995). In this sense, any time a mate slacks off in his/her focus on the partner, he/she is committing an infidelity.

Boylan (as cited in Thompson, 1983) includes the fulfillment of emotional and psychological needs outside the primary relationship as part of the definition of infidelity. When couples are not married but are dating or cohabiting instead, the parallel behaviors have different nomenclature. The term used is "extradyadic relationship" (Thompson, 1982). Extramarital or extradyadic relationships usually take place without the knowledge of the other partner (Hite, 1981) and are usually secretive.

Other types of "extra" relationships involve the knowledge of both partners. Comarital sex (Knapp, 1975, 1976; Rubin & Adams, 1986), and swinging, mate swapping, group sex, group marriage, and multilateral relations (Jenks, 1998) fall under this umbrella. Other terms encountered in the literature are *intimate friendships* (Ramey, 1977b) and affair (Whitehurst, 1969).

Thompson (1983) also includes extramarital intercourse, extramarital sex, and cheating as part of the list. He points out the need for operationalizing all the various definitions. Buunk (1980) introduced a continuum composed of behaviors that pertain to the lack of loyalty in couples' behaviors. He proposed a list that includes flirting, light petting, falling in love, sexual intercourse, and prolonged sexual relationship.

In his desire to provide clarity to the topic, Thompson (1983) created three conditions to consider when organizing information about extra relationship behaviors. The first is the nature of the behaviors (consensual/sanctioned vs. secretive/nonconsensual).

The second is the nature of the relationship that the behaviors violate (extramarital, extracohabiting, extramultilateral). And the third condition is the description of the actual behaviors (intercourse, petting, kissing, and homosexual genital contact).

Prevalence Rate of Infidelity

The prevalence of extramarital/extradyadic relationships has been the question for many researchers over time (Athanasiou et al., 1970; Bell, Turner, & Rosen, 1975; Billy, Tanfer, Grady, and Klepinger, 1993; Buunk, 1980; Forste & Tanfer, 1996; Hite, 1981; Hunt, 1974; Johnson, 1970a, 1970b; Kinsey et al., 1948, 1953; Laumann, Gagnon, Michael, & Michaels, 1994; Leigh, Temple, & Trocki, 1993; Maykovich, 1986; Pietropinto & Simenauer, 1977; Wiederman, 1997; Yablonsky, 1979). The most widely cited research project on prevalence is that of Kinsey et al. (1948, 1953). In this national study, 3088 men of all ages and 2000 women under 40 years of age were surveyed on their extramarital intercourse habits. The analysis of the data showed that 50% of men and 26% of women were engaging in extramarital coitus.

Wiederman (1999a) is a critic of this study. He points out that the sample used in the study, which was massive, was not representative of the United States population, and that, nonetheless, researchers have adopted what Wiederman calls "the myth" of the 50% rule and have used it as an assumption in much research.

Other prevalence outcome studies include findings similar to those of Kinsey et al. (1948, 1953). For example, Athanasiou et al. (1970), who surveyed 8000 married men and women of all ages (3/4 of them under 35 years old), found that 40% of men and 36% of women engaged in extramarital relationship; Johnson (1970a, 1970b), who surveyed 100 middle aged, reporting strong stability couples, found that 20% of the men and 10% of the women had engaged in extramarital relations.

Similarly, Hunt (1974), whose sample included 982 males and 1044 females, found a prevalence rate of 41% for males and 18% for females. Some, using only females in their samples—Bell et al. (1975) (N = 2262); and Maykovich (1986) (N = 100 white-middle class American women aged 35-40, and N = 100 middle class Japanese women aged 35-40)—found that 26%, 32%, and 27% of the women, respectively, were involved in extramarital intercourse.

Interestingly, those using only males in their samples—Pietropinto and Simenauer (1977) (N=4066); Yablonsky (1979) (N=771); and Hite (1981) (N=7239)—found that 47%, 47%, and 66%, respectively, of the men cheated on their spouse or girlfriend. Buunk (1980) surveyed 125 Dutch males and females and found that 43% of the males and 32% of the females were involved outside their relationship.

Contrary to the findings of the earlier studies, Billy et al. (1993), who surveyed a national sample of males aged 20-39 years, found an incidence rate of only 4%, and Forste and Tanfer (1996), who surveyed a national sample of women aged 20-37 years, also found only a 4% prevalence rate. Similarly, Leigh et al. (1993) found a prevalence rate of 3.6% to 6.4%. Slightly higher percentages were found by Laumann et al. (1994), where research shows that 3.8% of males and females combined had an extramarital partner in the past year, while 24.5% of ever-married men and 15% of ever-married women had cheated on their mates.

Although the sex research has yielded a myriad of data, the literature indicates that research on the topic of extramarital sexual behavior is problematic because of the inhibiting nature of the subject (Bullough, 1986; Catania, 1999; Catania, McDermott, & Pollack, 1986; Morokoff, 1986; Ochs & Binik, 1999). Some of the problems with the research include nonrepresentative samples, poor reliability of responses due to self-

report inhibitors, volunteer bias, and social desirability problems—attributable in large part to the sensitivity of the topic of sexuality (Bullough, 1986).

Some researchers endorse further work on the use of theory in sexuality research and point out in their publications that theory is the missing piece in that field (Edwards, 1973; Weis, 1998). Carballo, Cleland, Carael and Albrecht (1989) propose a fully developed research agenda for further studies that address conceptual frameworks and content of interview schedule. There are many articles on current ways of measuring human sexuality in research (Gribble, Miller, Rogers, & Turner, 1999; Lundervold & Belwood, 2000; Pinney, Gerrard, & Denney, 1987). Wiederman (1999b) proposes that "policy capturing" methodology be utilized when conducting sexuality research. He believes that this is a more direct way of quantifying the factors that influence respondents' judgment when they participate in studies. They affirmed what Rosenblatt (1966) found earlier—that societies that allow premarital and extramarital sex for both males and females rate romantic love much higher than societies that have a double standard between males and females.

Widmer, Treas, and Newcomb (1998) studied the attitudes towards nonmarital sex in 24 countries. A cluster analysis revealed the existence of 6 groupings for the 24 countries vis-à-vis similarities towards moral beliefs. The overall results of the 24 countries (Australia, Austria, Bulgaria, Canada, Czech Republic, East Germany, West Germany, Great Britain, Hungary, Ireland, Israel, Italy, Japan, Netherlands, New Zealand, Northern Ireland, Norway, Philippines, Poland, Russia, Slovenia, Spain, Sweden, and USA) were the following: 66% said that extramarital sex is always wrong; 21% said that it is almost always wrong; 9% said it is wrong only sometimes; and 4% felt that it is not wrong at all. Interestingly, when asked about their attitudes towards

homosexual sex, 59% of the same group responded that it is wrong all the time, 9% said almost all of the time, 9% said some of the time, and 24% said that it is not wrong at all.

In reviewing three decades of trends in sexual permissiveness in the Netherlands, Kraaykamp (2001) concluded that the most important influence on whether attitudes change or not is the trend related to structural developments (time periods) in which everybody in society is affected. It was interesting to note in his findings that churches have been able to keep their members from developing more permissive attitudes over time and that with the exception of sex before marriage where there was a convergence in the gap between men and women, gender differences in attitudes remained constant.

In this longitudinal study that utilized 8 surveys, Kraaykamp (2001) indicates that since 1960 tolerance for extramarital sex has increased and that the most notable jump in permissiveness was from 1965 to 1970. Forty-eight percent of his sample (N = 15,490) felt that unfaithfulness does not indicate a bad marriage, 19.45% said that a single affair does no harm to a good marriage, and 39.1% said that it is acceptable for a married man to have an affair.

Hunt (1974) studied the range of sexual behaviors (N = 2026) experienced by adults in the United States. His results support the idea that greater sexual experience is alive and well in contemporary times. People, in general, are experimenting more, demanding more from their sexual experiences, and enjoying more.

Attitudes and Gender Differences Among People

deMunck and Andrey (1999) propose that when romantic love is the basis for marriage in a society, it reflects a culture that allows both males and females to give or not give love freely. For them, romantic love is nothing more than the result of sexual

attraction and passion. Romantic love is an indicator of sexual equality between the sexes.

Glass and Wright (1988) and Rodgers (2001) report that the literature reflects that males experience more extramarital sex than do women and have more extramarital partners than do women. Men also tend to be more approving of extramarital sex (Glass & Wright, 1992; Wiederman & LeMar, 1998).

Schackelfold and Buss (1997b) studied cues that might pertain to infidelity (physical, sexual, emotional, verbal, and behavioral). They asked participants (N = 230, 114 men and 116 women, college age) to pick out information from four vignettes that indicated to them the presence of an affair in the relationship of the protagonists in the vignettes, and concluded that women have a lower threshold for inferring infidelity than do men.

Men are more prone to be unfaithful (Fisher, 1987; Hite, 1987). Spanier and Margolin (1983) found that men experience less guilt when unfaithful and feel more justified in their behavior.

Glass and Wright (1992) report that more people disapprove of extramarital involvement than engage in it. They observe that men and women seem to follow different codes of extra marital behaviors. Their findings indicate that the primary justifications for an affair are three: sex, romantic love, and emotional intimacy needs. With regard to gender differences and justifications, they found that men are more approving of *sexual* justification (for themselves), while women are more approving of *emotional* justification (for themselves).

When an extra relationship affair is present, a women is more pained by her mate's emotional involvement with the third party, while a man tends to be more pained

by his mate's sexual involvement with the third party (Glass & Wright, 1992; Mongeau, Hale & Alles, 1994; Wiederman & LaMar, 1998). Interestingly, Wiederman and LaMar also found that men were most upset by male-female sexual infidelity, whereas women found male-male sexual infidelity most upsetting. The study controlled for religiosity, sex-love-marriage association beliefs, erotophobia/erotophilia, and erotization of same-gender sexual contact. Their conclusion remained that both genders are most upset by the third party of an affair being male.

Scott and Sprecher (2000) reviewed a decade of literature pertaining to sexuality in marriage, dating, and other relationships. They discovered that 70% to 80% of Americans express complete disapproval of extramarital involvement. Thompson (1983) found that permissive attitudes towards extramarital sex are mostly associated with a person's premarital sexual permissiveness, high education, low religiosity, and being male. This finding seems to suggest that the same attitudes described by Hunt (1994) and Taylor (1970) in their study of the historical evolution of love, sex, and marriage, persist in today's society.

Liu (2000) applied the law of diminishing marginal utility and human capital theory to explain that, in marriage, the decline in a couple's interest in marital sex is linked to the length of the relationship.

Theoretical Typologies, Patterns of Infidelity and Relationship Dynamics

Dante Alighieri's metaphor for hell, purgatory, and paradise in his *Divine Comedy*, translated and presented by Mandelbaum (1980, 1982, 1984) can be used to describe the journey experienced by clients as they fall into the pit (hell), slowly ascend towards atonement (purgatory), and, ultimately, through forgiveness, proceed to trust and

rebirth (heaven). The therapist or counselor is the guide (Virgil) and must be a skilled navigator to assist clients in reaching their desired destination.

In reviewing the theoretical information relating to patterns of infidelity, this writer identified several typology models in the literature (Brown, 1989, 1991; R. Brown, 1999; Collins, 1999; Glass & Wright, 1985, 1988, 1992; Hendrix 1988; Lusterman, 1998; Kaslow, 1993; Maheu, 2003; Moultrup, 1990; Pittman, 1987, 1989; Staheli 1995). Additionally, literature on alternative lifestyles (open marriages and swinging) also exist (Jenks, 1985; Knapp, 1976; O'Neill & O'Neill, 1972; Rubin & Adams, 1986). And finally, literature on sexual addiction provides insight into the life of compulsive sexual activity that frequently translates into extramarital sex (Carnes, 1991, 1992; Schneider, Corley, & Irons, 1998).

Shirley Glass and Thomas Wright

In the sex research literature, the work of Glass (2003b) and Glass and Wright (1985) is frequently cited. Glass and Wright (1988) oppose the assumption many researchers make when they define affairs as exclusively extramarital sex. They point out that the term extramarital involvement and extramarital sex are not interchangeable descriptors when referring to "extra" relationships. In their own work (1985, 1992), they identified three types of affairs: (a) emotional involvement; (b) sexual involvement; and (c) sexual and emotional combination involvement.

They differentiate between emotional and sexual affairs by the types of behaviors included in the relationship. In an emotional affair (unlike in a friendship), secrecy, intimacy and sexual chemistry are present. Even when spouses are aware of the relationship, there is a part of that relationship that remains secret. In their earlier study

of extramarital sex (EMS), Glass and Wright (1985) noted a variety of intimate behaviors that can be part of a secret relationship and that can cause marital distress if discovered.

They propose that the "extra" relationship exists on a continuum from "slight" to "extremely deep." The sexual intimacies they observed include kissing, petting, sexual intimacy without intercourse, and intercourse. The intensity of the "extra" relationship changes, depending on what constitutes the relationship (e.g., one-night stand, long term). Glass and Wright (1988) urge therapists to conceptualize affairs within a broad range of emotional and sexual experience.

Frank Pittman

Frank Pittman, in his work alone (1987, 1989) and in work with a colleague (Pittman & Wagers, 1995), has proposed that affairs are not necessarily the result of a problem filled marriage. He believes that affairs sometimes happen simply because the person wanted to have an affair. Pittman drew on extensive work with couples over three decades to conclude and propose that there are four types of affairs: (a) accidental infidelity; (b) philandering; (c) romantic affairs; and (d) marital arrangements.

In accidental infidelity, the person finds himself/herself in an unplanned involvement. This type of affair does not include love and usually occurs when one is alone, when his/her partner is not available due to medical problems, pregnancy, or other reasons. Usually, these affairs are the result of bad judgment and pass as quickly as they arrive.

Philandering refers to the circumstance of a person making a career of participating in affairs. In these affairs, Pittman (1987, 1989, 1991) believes that if the person is male, he is fearful of women and works at avoiding intimacy and being

controlled. If the person is female, she is looking for Mr. Perfect. The affairs are exciting to the participants and have a certain dangerousness associated with them.

Romantics engage in romantic affairs. It is not uncommon for people involved in romantic affairs to be trying to escape a boring life. Frequently, one person will be "in love" while the other is simply involved for the sex. Two romantics together might leave their other relationships in pursuit of a better life. These affairs usually cause a great deal of pain to everyone involved.

Marital arrangements suit those people who openly or discreetly have agreed to see other people outside their marriages. The goal is to establish distance while maintaining some connection (perhaps because of children). Also a part of this pattern are behaviors designed to arouse the partner (e.g., flirtation, jealousy, revenge affairs).

Emily Brown

Emily Brown (1989, 1991) offers a five-pattern typology for conceptualizing affairs: (a) conflict avoidance affairs; (b) empty nest affairs; (c) out-of-the-door affairs; (d) intimacy avoidance affairs; and (e) sexual addict's affairs. Each of these patterns serves a different purpose in the primary relationship.

A conflict-avoidance affair usually presents itself because the couple is frustrated and does not know how to address and resolve conflict. This type of affair involves the male or female—typically aged 20 to 30 years and having been in the marriage for fewer than 12 years. The affair is usually brief and includes only a minimal level of emotional involvement.

The empty-nest affair is one where a person, usually male around the age of 40 years or more who has been in a long-term marriage (usually 20 years and up), finds himself unfulfilled in his relationship after the children leave home. During this time,

when the couple's developmental impulse mandates (Rock, 1986) reorganizing around one another now that the children no longer live at home, a person may find himself/herself unable to reconnect with his/her partner and, instead, becomes involved in an affair.

The out-of-the-door affairs usually take place in marriages that are younger than 15 years and are created to prompt the other partner to end the relationship. The betrayer, who is conflicted over family shoulds and his/her own wants, is unwilling to take responsibility for ending the relationship and, unable to face ending the marriage, banks on his/her partner to do so when he/she learns about the affair.

The purpose of an intimacy-avoidance affair is to create distance between the two marital partners. Usually, after the first 5 or 6 years of marriage, when the couple has jelled and become very intimate, the 20- to 30-year-old male or female will get involved in a brief fling that will put some distance between himself/herself and his/her partner. Either or both members of the couple might have an affair during this time in their relationship.

The purpose of the sexual addict's affairs is to make conquests and to engage in some daring and dangerous behaviors. This affair is prevalent among males of all ages and is not associated with length of the primary relationship. Usually, the addict feels empty inside and tries to fill the void by jumping from relationship to relationship without any emotional involvement. This type of affair causes much damage and humiliation to everyone involved.

E. Brown (1999) revised her typology and replaced the empty-nest and the out-of-the-door affairs with the split-self and the exit affairs. The split-self affair is one that typically takes place in midlife and tends to be serious, long-term, and passionate. It is rooted in childhood. The betrayer struggles between choosing the affair or the marriage.

The exit affair occurs when the marriage has deteriorated and the situation is unclear as to how it should be ended. The affair provides a viable reason to leave the marriage and typically, one spouse has already decided to leave. The members of the couple tend to blame the affair for the breakup of the marriage in lieu of looking to the problems in the marriage prior to the affair as the cause of the breakup.

Sexual Addiction

Other theorists and therapists who have studied sexual addiction include Bradshaw (1988, 1990, 1992), Carnes (1991, 1992), Levine and Troiden (1988), Schneider, Corley, and Irons (1998) and Woititz (1989). Carnes' work on sexual addiction conceptualizes sexual addiction as a progressive disease that intensifies in involvement over time.

This four-step cycle starts with preoccupation, the first stage, wherein the addict's mind is completely engrossed in thoughts of sex that create an obsessive search for sexual stimulation. Next the addict progresses to creating patterns (ritualization—the second stage), which lead to sexual behaviors and additional obsessive thinking. As the addict becomes more engrossed in his addiction, he/she moves to the next phase, compulsive sexual behavior. Here, the actual sex act is ritualized and the obsessive search for new partners intensifies. In the last phase, despair, the addict feels overwhelming hopelessness and powerlessness.

Schneider (1988), Schneider, Corley, and Irons (1998), and Schneider and Schneider (1989, 1990, 1996) have made major contributions to the field of sexual addictions and its treatment. Bradshaw (1988, 1990, 1992) and Woititz (1989) link sexual addiction to shame, resulting from the individual having grown up in a dysfunctional addictive family.

Not all theorists support the idea of sexual addiction. Levine and Troiden (1988) argue against the whole premise on which sexual compulsivity is based. They believe that what appears like sexual compulsion is in fact the result of cultural relativity (construct) similar to other constructs that describe mental illness. In their work, they point out that the nomenclature and criteria for describing sexual addiction behavior(s) are flawed and value laden. They proclaim that sexual compulsivity is not inherently pathological and that it is the result of learned patterns that are stigmatized by dominant institutions and so are judged as bad. They urge mental health professionals to remain cautious about "endorsing concepts which may serve as 'billy clubs' for driving the erotically unconventional into the traditional sexual fold" (p. 361).

David Moultrup

Moultrup's (1990) conceptualization of affairs is rooted in Bowenian theory (1987) and includes the concepts of differentiation, triangulation, multigenerational patterns and systemic regulation of anxiety. This framework in endorsed by other theorists and clinicians (Schnarch, 1991). Moultrup emphasizes the systemic and strategic significance of affairs in relationships and underscores the idea that inequitable power hierarchies and alliances are present in the affected relationships. These hierarchies and alliances must be reconfigured in the treatment of affairs. The less powerful (the betrayed) partner must be willing to stand on his/her own two feet and make independent requests (with consequences) of his/her partner.

IMAGO Relationship Therapy (IRT) Model

In IRT (Hendrix, 1988, 1992; Hendrix & Hunt, 1997), affairs are conceptualized as exits (violations of relationship boundaries) that will greatly damage a relationship. Affairs, along with addictions and insanity, are considered overly open boundaries that

must be closed so that the couple can use the energy that escapes out of these apertures to work on the relationship with each other.

R. Brown (1999) points out that 60% of couples who are afflicted with an affair will end up in divorce. He further asserts that affairs take place because there is an unmet need from childhood that is longing to be filled. He also proposes that affairs do not happen in relationships that are experienced as safe and passionate. This notion is not supported by all those who theorize about affairs (Levine & Troiden, 1988; Pittman, 1989).

The IRT typology is proposed by Hendrix (1988). R. Brown (1999) describes the IRT typology in detail. In IRT, affairs are conceptualized as a response to wounding that occurred during the individual's psychological and social journey of his/her development. This concept is rooted in depth psychology (Jung, 1971), and separation-individuation object-relations theory (Mahler, Pine, & Bergman, 1975). The actual IRT developmental paradigm (Hendrix, 1988) is made up of seven stages. The model for addressing affairs utilizes only four of those seven stages (attachment, exploratory, identity, and concern). The four types of affairs serve to meet the unmet needs of childhood that remain unmet in the primary relationship (the marriage).

The first type is the attachment affair. This affair, which is an exit from an avoider/clinger relationship dynamic, is for the purpose of being held close and being touched. The second type of affair, the exploratory affair, which is part of the distancer/pursuer dynamic, serves as the tool to manage closeness between the couple. The identity affair is one that involves a couple who tend to be diffuse/rigid, respectively. In this affair, the members of the couple seek to feel more in control or to become more visible through the relationship with the lover. In the competence affair, where the

couple is made up of a competitor and a passive compromiser, the infidel seeks to soothe insecurities stemming from feelings of incompetence or helplessness and uselessness in the relationship.

Don-David Lusterman

Lusterman (1998) defines infidelity as the breaking of trust and states that it occurs "when one partner in a relationship continues to believe that the agreement to be faithful is still in force while the other partner is secretly violating it" (p. 3). His theoretical typology includes eight conceptualizations for infidelity: one night stands; philandering; sexual identity affairs; sexual addiction or Don Juanism; exploratory affairs; tripod affairs; retaliatory affairs; and exit affairs.

One night stands are extra-relationship sexual encounters that occur due to unusual circumstances or convenience. They happen one time only as a result of someone finding himself/herself in a unique situation. Typically, the person feels remorse and learns from his/her experience. He/she may or may not tell his/her partner about it.

Philandering involves the systemized, consistent pursuit of sexual conquests that are typically impersonal and compulsive. If remorse exists on the part of the betrayer, it is usually because the person regrets having been discovered. He/she might stop his/her behavior if the stakes are great enough.

Sexual identity affairs are the result of conflicted feelings regarding ones own sexuality. Thoughts of being gay, lesbian, or bisexual remain so deeply buried and repressed from adolescence that eventually they emerge later in life. The person may now be ready to explore those old impulses repressed from earlier stages of development that he/she finds himself/herself involved in a secret life that includes betraying his/her committed relationship.

Sexual addition or Don Juanism refers to the compulsive need to engage in sexual activity. The affairs are nonemotional, nonromantic, and nonrelational. Sexual addicts tend to constantly remind themselves of their inadequacies, hold distorted beliefs about themselves and the world around them, tend to want to escape painful and suppressed emotions, deny they have a problem, and have difficulty coping with stress.

Exploratory affairs tend to occur when a person becomes aware that his/her marriage is in deep trouble and has not yet decided whether to stay or leave. Some exploratory affairs end when the betrayer realizes that the marriage can improve. Others become the precursor for divorce. This type of affair can provide the betrayer with the courage to leave inasmuch as some of what the affair teaches is that he/she can be a viable partner to someone other than the spouse.

Tripod affairs occur when the marriage is unhappy but the person chooses to remain in it for a variety of reasons, such as economic, fear, and children. The tripod affair helps the marriage that cannot stand on its own two feet stay erect. The third party is added to the relationship for support and to provide for some of what the marriage cannot.

A retaliatory affair is one that occurs when the betrayed responds to the pain of having been betrayed by having an affair of his/her own. Women tend to engage in these types of affairs more frequently than men do because they might feel less able to leave the marriage than the man does. This type of affair is usually not intended to end the marriage but simply to even the score.

Exit affairs typically offer the betrayer the avenue to leave his/her primary relationship. By the time the person is in this affair, he/she has already decided to leave the marriage. The couple may enter therapy at the coaxing of the betrayer. He/she

sometimes wants to procure support for the spouse he/she is about to leave. When the betrayed partner discovers the affair, the rage that the betrayed partner experiences and expresses is used as further proof that he/she is not the partner the betrayer wants to be with.

Lusterman (1989, 1998) offers a treatment model he calls Protracted Marital Infidelity (PMI). He points out that at the core of the work to be done is the need to navigate through a web of lies and deceit. The effects on the couple are similar to the effects of Post Traumatic Stress Reaction (APA, 1994) and as such can make therapy a very intense process.

Eaker-Weil and Winter

Eaker-Weil (Eaker-Weil & Winter, 1994) is an Imago relationship therapist trained in the Bowenian tradition. She suggests that adultery is a forgivable sin and offers a typology of affairs that she calls 'states of the affair' (p. 21): the pseudo-intimacy affair; the peacekeeping affair; the escape hatch affair; the love-seeking affair; the compulsion-driven affair; and the affair caused by physical or psychological problems.

The pseudo-intimacy affair occurs when people have not properly separated or individuated from their caregivers. When proper individuation does not occur, persons tend to be fugitives from intimacy and often create a triangle to use as a wedge to drive between themselves and their partners.

The peacekeeping affair is a desperate, dysfunctional effort to keep a marriage or relationship going. Couples who find themselves in this type of affair tend to be those who try to avoid conflict at any cost. In their view, a polite marriage is a happy one. Talking about the buried anger is most important for the recovery of this type of relationship after the infidelity is discovered.

The escape hatch affair is one used when a person finds himself/herself trapped in a marriage or relationship that is loveless or abusive. Unable to leave the primary relationship, he/she will become involved in this type of affair so that it will be discovered and his/her partner will end the relationship. Sometimes, this type of affair takes place when latent homosexual drives emerge.

The love-seeking affair is one where the betrayer may find the love he/she did not find earlier when he/she married his/her partner. Once they become involved in this type of affair, they will more than likely leave the marriage. This type of affair includes feelings of elation and sexual excitement and is most likely to take place at the end of a decade of the person's age.

The compulsion-driven affair is one in which the Don Juan or vamp is ducking intimacy altogether. Some of these betrayers are sexual addicts who use promiscuity for a quick fix to numb their pain. The person is obsessed with the pursuit of sexual encounters/partners and frequently will suffer the loss of his/her job, family, and/or marriage.

The affair caused by physical or psychological problems is one where a medical condition, substance abuse, or psychic disorder, such as depression or manic-depression, may spur partners to affairs or promiscuity. Sometimes, the inability to control the spouse's condition makes the affair difficult to stop. The person may suffer great losses in his/her life.

Subotnik and Harris

Subotnik and Harris (1994) offer a typology of affairs that exists on a continuum based on the degree of emotional involvement in the affair. The continuum spans from the least amount of emotional involvement to the most. At the extreme of least amount

of emotional involvement is the serial affair, then flings, then romantic love, and then long-term.

In the serial affair, the person lacks total emotional investment. Typically, this is a series of one-night stands or a series of short term involvements. In the fling affair, the person does not make an emotional investment. It is a one-time event. Sex, like in the serial affair, is part of the equation. It typically does not pose a threat to the marriage but does cause pain when discovered.

The romantic love affair involves a high degree of emotional investment and is central to the romantic partners. They spend time together planning how to integrate their affair into their regular lives. There is stress around thoughts of leaving the marriage for the affair partner.

The long-term affair spans years or even a lifetime. In this type of affair, the affair partners feel very emotionally involved with each other. When this type of affair exists in the marriage of two people, it is conceivable that the betrayed is aware of the affair either covertly or overtly and may have quietly agreed to this type of lifestyle. For most betrayed partners, it is an arrangement agreed to by default.

Lana Staheli and Florence Kaslow

Staheli (1995) focuses on the triangularity of affairs. She proposes that people can be successful at affair-proofing their relationships (Staheli, 1999). In her work, she proposes a typology that includes seven types of affairs: loving affairs (are used for friendship and for a refuge from everyday responsibility); bridge affairs (occur during transitioning times or tough times in life); hate affairs (are used to hurt and deceive the affair partner or the spouse); sex affairs (are for physical contact without emotional attachment); sexual adventure affairs (are used for sport and driven by experimentation,

challenge or rebellion); sexual conquest affairs (are used when the betrayer is trying to prove something—typically lacks emotional involvement); and cyber affairs (takes place over the computer and may be physical or emotional). Staheli urges couples to focus on their relationships so that an affair does not have to create the end of the marriage or relationship.

Kaslow (1993) writes of another type of affair—the one that turns fatal. She points out that, during extramarital liaisons, people experience such strong feelings that they sometimes act impulsively. The common feelings during an affair include hot desire, irresistible urges, and claustrophobia in the marriage. Affairs can produce children, which can serve as a constant reminder of the affair long after it is over. In the worst-case scenario, the affair can turn fatal.

Sometimes, spouses are left bewildered when they learn of their mate's affair after the death of the mate. Kaslow (1993) suggests that couples in therapy must be sure that they achieve the necessary tasks to assure a full closure after the affair. Through the therapy process, the infidel must have apologized and asked for forgiveness, and must have made restitution to achieve atonement through good behavior. Therapists must be aware of their own feelings and attitudes surrounding affairs and infidels.

Cyber-Infidelity

Staheli (1995) defines cyber-infidelity as "an intimate or sexually explicit communication between a married person and someone other than their spouse that takes place on the computer or the Internet" (p. 73).

Collins (1999) introduces the notion of "practical fidelity" (p. 243), a term that emphasizes interaction between individuals conducted in physical space. She proposes

that virtual relationships should not be regarded as having the same importance as "body based" relationships (p. 243).

Collins (1999) describes two types of cyber affairs—the on-line erotic affair (also called the affair of the cyberloins) and the on-line romantic affair (or the affair of the cyber heart). Collins points out that if society removed all the obstacles that make infidelity such a bad concept, she believes that although some people would want to build fidelity into their relationships, feminists would have no real reason to recommend it.

Maheu (2003) offers an elaborate typology for cyber-infidelity. She delineates the many issues facing practitioners who try to ethically approach treatment either face-to-face or in a virtual environment. The typology she proposes includes: the covert cyber-affair, which is a secret relationship where communication occurs electronically in secrecy from partners; the overt cyber-affair, which exists with the knowledge of the primary partner(s) who either may approve or disapprove of the communication; the menage-a-trois cyber-affair, which is the type of affair where the couple engages in sexual communication with another person in the virtual world; and, lastly, the group cyber-affair, which is the type of affair where the infidel meets others in a virtual community with the intention of erotic exchanges.

Maheu (2003) cautions therapists that the issues they will have to address with clients that enter therapy to work on the effects of cyber-affairs include coming to terms with the damage to the self and with the deception that are associated with cyber-affairs.

Open Marriage and Swinging

Although there has been a decline in the prevalence of open marriages (Rubin & Adams, 2001) and of swinging (Jenks, 1998), the practices still exist. Knapp (1976)

conducted an exploratory study of marriages that were sexually open and Rubin and Adams (1986) studied outcomes of sexually open marriages.

Knapp found that the 17 sexually open marriages she examined had clear-cut rules about ways to conduct their relationships. When entering therapy, these couples tend to look for therapists with liberal attitudes because when they present for therapy, it is usually not due to the open relationship.

Knapp (1976) found that when the ground rules of (a) honesty with the spouse; (b) acceptance of emotional involvement with outside partners as long as the relationship with the spouse was kept primary and the outside partner was aware of this rule; and (c) pursuit of each spouse's own outside interests separately were preserved, the couples reported benefits to their primary relationships that they attributed to their sexually open marriages. In fact, those couples reported better fulfillment of personal needs, social and sexual excitement about the new experiences, increased communication and enjoyment of sex with the spouse, a lessening of jealousy and possessiveness, enhanced feelings of freedom and security in their relationship, and an increase in each of their ability to be himself/herself fully while minimizing role-playing and games.

Rubin and Adams (1986) conducted a follow-up study to a 1978 study on sexually open marriages (with a matched sample of 82 couples). In this study, they sought to determine if, as was found in the earlier study, there is no statistically significant difference in marital stability between the sexually open marriages and the monogamous ones, and to review if couples in a sexually open marriage divorce at a greater rate than exclusive couples.

Of the original samples, 68% of the sexually open marriages couples and 82% of the originally exclusive couples responded (new N = 23 and 32, respectively). They

discovered that, of the 82 couples studied earlier (55 of whom were in the new sample), of the 23 that had been sexually open, two couples had changed to a contract of exclusivity. Of the 32 couples that had been exclusive, one couple had changed to an open marriage.

Marital stability was discovered to remain the same over time. Of the couples that reported marital dissatisfaction, the associated variables were identified to be (a) higher education in women; and (b) women working outside the home, irrespective of group. The data also indicated that couples in sexually open marriages do not divorce at a greater rate than do couples in monogamous exclusive marriages.

Rubin (2001) revisited the alternative lifestyles of swingers, group married, and communes. He reported that the North American Swing Club Association was then made up of 310 affiliates having, grown from 150 in the past 5 years. He cites Gould and Zabol (1998) as noting that there are 3 million married, middle-aged, middle-class swingers or, as the new language calls them, "lifestyle practitioners" (p.721). Group sex is now called polyamory and that there are 250 polyamory support groups (mostly through the internet). Citing W. L. Smith (1999), Rubin (2001) reports that there are 3000 to 4000 communes in existence and that according to Newsweek (Murr, 2000), there are between 20,000 and 50,000 Mormon splinter groups that live in polygamous families.

In the research related to the practice of swinging, Jenks (1985) points out that over the last 20 years, reviews on this issue have been dormant. His article's purpose is to update the literature. He clarifies the fact that words such as comarital sex and mate swapping are also used when describing this population of couples. Jenks offers a profile

of a typical couple that "swings." He reports that swingers tend to vote Republican but, overall, hold a liberal sexual predisposition and have low degrees of jealousy.

In addressing the reasons couples tend to give when discussing their involvement in this lifestyle, Jenks (1985) lists need for variety in sexual partners and experiences, pleasure and excitement for the "forbidden fruit," meeting new people, voyeurism, and recapturing one's youth. Additionally, he offers a process model that tends to apply to the lifestyle of those who engage in swinging: passive (just learning); active (making contact); and commitment (actual involvement).

Couples report that the typical problems associated with swinging that also serve as reasons to stop swinging include (a) sexually transmitted infections (VD, AIDS); (b) finding people; and (c) high time demands. Although no studies exist on the negative impacts of swinging on marriages, Jenks (1985, 1998), referring to a study he conducted (unpublished) in 1986, claims that 91% of males and 82% of females indicated that swinging improved their marriage. Less than 1% of the females reported displeasure with swinging.

Disclosure and Discovery Process

Disclosure will offset a crisis (Glass, 2003a, 2003b). The process should be guided by and begin as a quest for truth and information seeking a healing exploration with understanding and mutual empathy as a goal (Glass & Wright, 1997). The betraying partner should offer information openly. Secrecy and a tendency to want to protect the other (wo)man will rewound the betrayed partner.

Typically, when the couple is in the process of disclosure, the interaction will most likely appear adversarial. The betrayed partner may appear like an interrogating prosecutor in a trial (Staheli, 1995). The process should begin with simple questions like

who, what, when, where, how, and why. Glass and Wright propose giving the betrayed partner index cards on which to write all other questions, with the promise that they will all be answered in due time. Initially, instructions are given that they not discuss the affair at home, reserving the discussion for therapy sessions. Working through the disclosure phase should be achieved slowly, with impeccable honesty, and a great deal of empathy. Disclosure is a more structured process than discovery.

When a partner discovers that his/her mate has been unfaithful, she/she immediately begins the traumatic response. Frequently, the betraying partner will deny the existence of the affair and more secrecy is piled on top of an already established web of deceit. When more lies are told, recovery is even more complicated (Schneider, Corley, & Irons, 1998).

Glass (2003b) offers advice on how partners should confront their suspicions. Her advice can be helpful to clinicians as they prepare clients to confront their partners. She suggests that partners know what they hope to gain through the confrontation, that partners not set up "truth traps," that partners give themselves time to cool down and become calm before confronting, and that the partners consider writing down their thoughts first. With regard to the confrontation itself, Schneider, Corley, and Irons (1998) suggest that partners share as much information as possible and that the suspicious partner understand that disclosure is a process and not a task and as such, be prepared to learn more information with the passage of time.

Glass (2003b) emphasizes the importance of the three stages of disclosure—truth seeking, information seeking, and mutual understanding—during the disclosure process (which is evolutionary by nature). She encourages betrayed partners to control destructive outbursts, remain silent during the disclosure so that information will flow

more easily, and curtail interpretations. Sometimes, these suggestions are difficult to implement because shortly following learning that an affair exists, the betrayed partner will begin to experience posttraumatic stress symptoms.

Glass (2003b) cautions betraying partners to avoid certain behaviors during the disclosure process. She points out that when the betraying partner either avoids telling the truth (when asked or when the opportunity is present), continues to deny that he/she is/was involved in the affair(s), stonewalls by refusing to talk about what he/she now may consider bad and wrong behavior, and discounts the severity of the impact his/her affair has on the committed relationship, it will be very difficult to make progress towards the next phase of recovery. If these actions persist, then the betrayer may have little to no willingness to end the affair and/or to return to the marriage.

Sometimes, the betraying partner may also exhibit posttraumatic stress symptoms. Therapists must prepare themselves to be available to their clients when they agree to provide clinical treatment—if not, a referral may be in order.

The Clinical Treatment of Infidelity/Betrayal

The literature on the treatment of affairs is primarily anecdotal and the result of clinicians and philosophers making observations within their own caseloads or worlds (Belson, 1989; Brown, 1989, 1991; Eaker-Weil & Winter, 1994; Finzi, 1989; Greenwalt, 2000; Lusterman, 1989; Pittman, 1987, 1989a, 1989b; Taylor, 1997). The majority of the research is focused on attitudes, opinions, and prevalence (Glenn & Weaver, 1979; Glass & Wright, 1992; Shackelford & Buss, 1997a, 1997b; Shackelford, Buss, & Bennett, 2002; Shackelford, LeBlanc, & Drass, 2000, Wiederman & LaMar, 1998). There are some qualitative studies that have examined client stories of infidelity (Gordon, Baucom & Snyder, 2004). There are many self-help books on ways to survive and work through

affairs (e.g., Glass, 2003b; Staheli, 1999), in addition to the many Internet chat rooms and websites (not included in this literature review).

Barnes (1999) published a book on how a person can best manage his/her affair passionately, with discretion and dignity, a most helpful publication for those engaged in open relationships, swinging, or simply embracing the worldview that extradyadic relationships are appropriate. The plight of "the other woman" has also received some attention in the literature (Richardson, 1985; Tuch, 2000).

Working through an affair is a difficult and lengthy process that takes at least one year to stabilize and longer to complete (Young & Long, 1998). The standard of care is based on the idea that once the crisis is stabilized, then the work of the couple focuses on the underlying issues of the relationship (Brown, 1991; Pittman, 1987, 1989; Glass & Wright, 1988; Hendrix, 1988). Research has shown that 30% of couples present with or openly acknowledge an affair at the onset of therapy (Glass, 1999a; Thompson, 1984), while 30% more reveal an affair during the course of therapy.

Most therapists endorse the disclosure of affairs (Brown, 1991; Glass & Wright, 1988; Pittman, 1987, 1989). Once the affair is open for discussion, the couple must focus on whether or not to continue the relationship (Bellafiori, 1999; Brown, 1991; Glass, 1999a, 1999b; Glass & Wright, 1992; Lusterman, 1998; Moultrup, 1990; Pittman, 1987, 1989; Schnarch, 1991; Abrahms-Spring, 1996; Staheli, 1995; Subotniik & Harris, 1994; Young & Long, 1998) and decide whether or not to stay together. Imago relationship therapists strongly support the couple's remaining together and working through the wounds that motivated the affair to begin with (R. Brown, 1999; Eaker-Weil & Winter, 1994; Eaker-Weil & Tuttle, 1998; Hendrix, 1988; Hendrix & Hunt, 1999; Love & Robinson, 1994; Luquet, 1996).

A summary of treatment issues presented and addressed by the authors cited in the above paragraph include the following:

- Revealing the affair and/or crisis support. Some researchers (Cottone, 1996; Glass & Wright, 1988; Schneider, Irons & Corley, 1999) point out that the therapist's own experience with extramarital affairs will influence whether or not he/she encourages clients to disclose the affairs. (Their findings indicate that those therapists whose own backgrounds include affairs will be more liberal in attitude towards affairs and will also be more tolerant towards keeping some information secret.)

- Suspending the decision to continue or end the marriage until stability is regained (depending on the type of affair and/or if the decision is already made in therapy). Imago therapists ask clients to commit to 12 sessions without deciding. The underlying treatment belief is that when the clients begin to improve communication and to achieve safe intimacy with one another, they will be able to validate and forgive each other (Eaker-Weil & Winter, 1994; Eaker-Weil & Tuttle, 1998) and resume with an enhanced relationship.

- When working with either member of the couple (the infidel and the spouse), teach patience, perseverance, communication skills, self-care, problem-solving and teamwork. Schnarch (1991, 1997) encourages clinicians to help couples differentiate and mature so that their relationship can become passionate and a crucible for intimacy.

Glass and Wright (1997) and Lusterman (1995) term infidelity as a trauma and work on reconstructing the marriage using the trauma model (Janoff-Bulman, 1992). Glass and Wright (1997) describe the traumatic reaction following the discovery or disclosure of an affair as similar to that of Post Traumatic Stress Disorder (APA, 1994).

The symptoms include intrusion (recounting and reexperiencing the trauma); constriction (avoidance and numbing behaviors); and hyperarousal (physiological arousal) and extreme hypervigilance. Lusterman (1995) includes the idea of protracted marital infidelity to his assessment practices and believes that the stress reaction will depend on the duration and depth of the affair. The traumatic reaction takes place as a result of shattered assumptions about physical, emotional, psychological safety in the committed relationship.

Glass and Wright (1997) treat couples by the following:

- Creating safety and hope in the therapy.
- Clarifying the contract the couple has with each other about their relationship.
- Normalizing the traumatic reactions due to betrayal.
- Reversing walls and window (a detriangulation technique called "stop and share").
- Promoting positivity and caring in the couple.
- Balancing affect and crisis.
- Utilizing individual sessions.
- Assessing suicidal and homicidal ideation.
- Anticipating crises and relapses.
- Managing the traumatic reactions (intrusion, obsessive ruminating, flashbacks, constriction, hyperarousal).
- Teaching the betrayed spouse to be a detective.
- Utilizing the therapist's deception detectors.
- Developing constructive communication patterns.
- Exploring the content of the affair (individual stories of the partners, extramarital attitudes and values, psychodynamic aspects, the needs of the individuals, tell the story of the marriage, discuss marital and sexual satisfaction, tell the history of the marriage, discuss equity issues, and explore dysfunctional patterns in the relationship).
- Building the narratives of the affair.
- Creating meaning in the relationship (forget the pain but remember the lesson, achieve forgiveness, recommitment and reclaim lost territory).

In her clinical work with couples, E. Brown (1991, 1999) observed that therapy outcomes differ with the various types of affairs. The prognosis for couples in conflict avoidance and intimacy avoidance affairs is excellent and the probability of divorce is low. At best, the couple can emerge from therapy with a solid marriage and newfound hope in their relationship. At worst, other affairs or divorce may take place.

With sexual addiction affairs, although the probability of divorce is low, the best result from therapy is that the family is now in recovery. The prognosis for resolving the couple's issues is poor. With empty nest affairs, the probability of divorce is above average, but if diligent, the couple can emerge with a revived marriage. Divorce or empty-shell marriages are also common. Lastly, in the out-of-the-door affair the

prognosis for resolving the issues is very good because the couple can come to terms with the ending of the marriage and the grieving of its loss.

Pittman (1987) proposes a series of seven steps in his treatment program for affairs:

- Respond to the emergency.
- Bring everyone together.
- Define the problem.
- Calm everyone down.
- Find a solution.
- Negotiate the resistance.
- Terminate.

When couples suspect or know that an affair is present in their relationship, they frequently engage in either self-prescribed or therapist prescribed bibliotherapy. Some authors who have contributed books useful in this endeavor include Botwin (1988), Hajcak & Garwood (1987), Hein (2000), Kirshenbaum (1997), Lerner (1993), Lusterman, (1998), Maslin (1994), Pearsall (1987), Robbins (1998), Schneider (1988), Staheli (1999), and Subotnik and Harris (1994), among many others.

Carnes (1991) and Bradshaw (1992) endorse 12 step programs for the recovery of sexual addiction. The models of codependent (Woititz, 1989), in addition to individual, couple, and family therapy, promote self-help groups to address the spouse's own dysfunctional behaviors and boundary setting.

Clinical Dilemmas in Treatment

As with any traumatic situation that creates "emotional distress" and a disruption that might even include danger in the clients' lives, therapists must intervene and decide when faced with the following classical clinical decisions:

- Whether a client needs to be hospitalized or whether an alternative intervention to hospitalization can be created.

- How to handle divided loyalties between the needs of the client and the therapist's commitment and mandate to protect society.
- Whether to go forward with interventions that might make sense for that client but are clearly contra-indicated by the practice protocols.
- Deciding when to break confidentiality without written permission from the client.
- How to handle dual relationships with clients that tend to be part of the clinician's community outside the office.
- How to handle the troubling task of managing colleagues who might lack competence, professional conduct, or who might have an impairment such as a drug addiction or an emotional unstable condition.

According to Scaturo (2002), in 1997 Dryden asked 14 master therapists their opinions on the clinical dilemmas encountered by therapists. Dryden collapsed the responses into six categories:

- The intractable patient (the nonimproving patient).
- The dilemma of brief therapy as it impacts the client.
- The dilemma of managed mental health care with its many mandates.
- The dilemma of sexual emotions that arise during therapy.
- The dilemmas of those concerns about the sociopolitical nature of therapy raised by feminist therapy.
- The dilemma of the self-care of the therapist and when to put his/her interest ahead of the client's.

Other clinical dilemmas encountered by therapists according to Scaturo and McPeak (1998) are (a) the directives in cognitive-behavior therapy, (b) the blame as it manifests itself in systems models of therapy, and (c) the psychological assessment (labeling) for the purpose of planning treatment interventions.

Scaturo (2002) lists handling those concerns regarding the sociopolitical nature of therapy as raised by feminist therapy as a main dilemma encountered in therapy. This

dilemma warrants special attention by therapists inasmuch as it deals with power differentials due to gender, race/ethnicity, sexual orientation, economics, age, and social-status, between therapists and clients, and between and among the members of the treatment unit.

Because these issues are pervasive in all types of therapy, including the treatment of betrayal, taking special care not to disenfranchise clients from their human rights is an ethical obligation clinicians must keep in mind as they conduct therapy. Becoming subjugated to prescribed, oppressive roles in the service of one's relationships is a decision that only can be made by the clients for themselves if that is what they wish—and clinicians must be aware of their own biases in this regard.

This study analyzes the effect of gender and of clinical experience, personal experience, and family of origin history with infidelity, on the position clinicians hold when they make therapeutic decisions about the disclosure of an affair during couples therapy.

Dilemmas Encountered by Clinicians working with Infidelity

In addition to the generic dilemmas listed above, the clinician, when treating couples affected by infidelity or its aftermath, has to manage a series of dilemmas that are typical of this type of work. Olson, Russel, Higgins-Kessler, and Miller (2002), through a grounded theory qualitative study, discovered a three-stage model for processing the crisis of infidelity. Specifically, they outline three nonlinear phases to the process: (a) the roller coaster, (b) the moratorium, and (c) the rebuilding. They developed this model from interviewing couples that had experience with infidelity and especially with what happens immediately following the disclosure of the affair. Similar models are embraced by Rhodes (1984), Pittman (1987), and Abrahms-Spring (1996).

All of these models imply that, immediately following disclosure, an intense crisis ensues, followed by periods of sadness and distance that culminate in either the restructuring of the relationship or the termination of the relationship.

Others (Glass, 2003b, Glass & Wright, 1988, 1997; Lusterman, 1995, 1998) embrace a trauma model to conceptualize and treat the disclosure of an affair. Each model includes the assumption that to arrive at posttraumatic resolution, couples must experience shock, must work through the impact of the shock, and must recoil from the pain (Herman, 1992). Resolution includes first the establishment of trust (in therapy and in the relationship), next remembering and mourning (the relationship vision preaffair disclosure) and, finally, reconnection (in a new way—maybe as divorced friends).

The discovery of a secret affair triggers the onset of a debilitating crisis in both the betrayed and betraying partners (Abrahms-Spring, 1996, 2004; Ahrons, 1994; Brown, E., 1991, 1999; Glass, 1998, 2003a, 2003b; Glass & Wright, 1988, 1997; Moultrup, 1990; Pittman, 1987, 1989; Subotnik & Harris, 1994). The clinician must rise to the occasion by making quick decisions regarding safety issues, crisis intervention and crisis support. When the therapist participates in unearthing the affair, preparing for the crisis can be helpful.

The couple or individual who present(s) with having recently discovered an affair might from the onset exhibit an array of psychiatric symptoms resembling those of Post Traumatic Stress Reaction described in the fourth edition of the International Version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 1994). Their symptoms might include suicidal ideation, homicidal ideation, or intense, undirected anger.

The first dilemma the clinician might encounter has to do with whether or not the client needs protection from himself/herself and/or whether others need protection from him/her. How should the clinician in fact handle his/her own divided loyalties between the needs of this client and the mandate to protect society? And, what will facilitating the hospitalization of one or both reluctant members of the couple do to the therapeutic relationship between the clinician and his/her client(s)? Sometimes clients feel so abandoned, angry, and demoralized that they decide their therapist can no longer be trusted. This can create unproductive distance between the clinician and the client(s).

Another dilemma for the clinician involves his/her making the determination of what the appropriate ways to manage the clients' roller coaster feelings are. He or she must decide if it is acceptable to give advice or should his/her stance be one of active listening only? Giving advice is contraindicated in the professional protocol (AAMFT, 2001, Code 1.8), although some clinicians suggest that when a crisis is present, the therapist should take an active and directive stance so that problems may be solved (Haley, 1976).

The choice is difficult because this is a time when although the client(s) might not meet the criteria for inpatient hospitalization, his/her judgment might be so poor and impaired that he/she is acting impulsively and recklessly, not in his/her own best interest or in the best interest of his/her family. The clinician must intervene—but how?

What can further complicate the matter is the fact that during this stage in the process of recovery, the individuals typically feel emotionally disconnected from their partners and don't wish to lean on them, to support them, or to be supported by them. Ambivalence is rampant. The clients may have an increased need to lean on the therapist

during this time and in the process, might share confidences that they expect will remain confidential.

This can prove to be a very difficult dilemma to resolve if the client shares information that cannot be ignored by the clinician without his/her violating his/her legal and/or ethical obligation. When can clients be free to say whatever they need to say in therapy without suffering the repercussions that come from being candid?

Assisting the couple to create or maintain support from their children, family and friends during this time can be a challenging undertaking for the therapist attempting to coach them.

Glass (2003b) suggests that couples should be leery of people who are not friends of the marriage/committed relationships when they lean on others. And, the information shared should be chosen carefully because once the couple rebuilds the relationship, those friends and members of the family who were told too many details about the affair might not be able to forgive the partner that strayed. This will cause difficulties for the members of the couple as they try to reenter their family and social circle once they decide to remain together. Clinicians must be prepared to coach couples who inquire about what to tell and who to tell.

Edell (1983) proposed guidelines for disclosing information to the couple's children. He proposes that children should never be told specifically about the existence of an affair unless they are older (over 18 years of age) and they initiate the discussion. He suggests that parents talk openly with their children about the turmoil, about the feelings of distress in the home, and, depending on the ages of the children, about limiting the details. Reassuring children about the future of the family and the place they hold in it is the most important goal.

As the process of therapy moves from the roller coaster to the moratorium stage, depression, isolation, hopelessness, intense ambivalence, and loss of desire and interest in therapy and in life set in. The next dilemma facing the clinician is whether or not he/she should push the clients to remain in therapy or whether he/she should relent and let the clients isolate from or drop out of therapy despite the fact that the issue/problem is not yet resolved.

Should a therapist who believes that more progress can be made encourage the client to 'hang in there' if that client feels like giving up on the relationship and on therapy? How does the clinician explain additional sessions (if the client is at an impasse)? And, what if the client is out of sessions (due to lack of insurance coverage)? Should the therapist continue with or without pay so not to abandon the client(s)?

Once a presenting problem is conceptualized in the context of the couple's dynamic (a dilemma on to itself), another dilemma emerges—that of defining success. With regard to the resolution of problems related to infidelity, what is success? Is it divorce? Is it returning to predisclosure, the preaffair status quo? Is it a new and improved relationship? What if one partner wants divorce and the other does not? And what if one partner is gay or lesbian and the other heterosexual? What is a clinician to do?

In therapy, multicultural issues can create a variety of dilemmas for clinicians. For example, members of a couple may have differing worldviews and beliefs about affairs and their appropriateness. In some cultures, affairs are accepted with more ease than in others (Sanders, 2001; Widmer, Treas, & Newcomb, 1998). What if one of the partners feels entitled to have affairs while the other believes it is a violation of their relationship commitment? And what is the solution if the affair is (as often is the case)

just one of the issues in a relationship that is laden with violence, substance abuse, and other dangerous complications?

Additional dilemmas inherent in the work with couples suffering from infidelity are presented by Moultrop (1990) and Abrahms-Spring (1996). Moultrop's outline of dilemmas includes a systemic view of the couple. He writes that when clinicians assess, diagnose, and plan the treatment of couples, they must answer the following questions: How is the affair crisis going to be defined and understood? What happened? How did it happen? What does it mean to the members of the couple? And what interventions are appropriate? And they must determine what those entities that influence the emotional system of the couple are. This is essential to positioning the treatment of the couple in the context of their lives, and so the clinician must: (a) identify those members of the couple's life who are part of and are influenced by the affair, which include the nuclear and extended families, the immediate social network, and the broad social system; and (b) the therapist's own intangible influences due to his/her own beliefs and judgments, along with the influence of the larger professional community, which holds stances that can have a profound effect on the therapist's answers to the questions. And what about the clinician's own gender bias and background and their effect on his/her answers to the questions?

The Professional Community Speaks Directly on Infidelity Dilemmas

In her doctoral dissertation, through a Modified Delphi Study, Brandt (1992) collected data on the extramarital affair from a clinical perspective. She surveyed 43 clinicians and collected 23 responses to the question: "What aspects of your therapeutic work with extramarital affairs have presented the greatest difficulty to you?" (p. 62). The responses appear in order from most difficult to least difficult:

- Violent/abusive behavior.
- The victim who obsesses.
- Infidel lies about ending the affair.
- The infidel not truthful about affair.
- Covert agendas in treatment.
- Want to continue affair and marriage.
- Problems resolving betrayal.
- Infidel tries to control partner.
- Confidentiality/refusal to divulge.
- Impact of affair on children.
- Refuse to give up being the victim.
- Affair reflects repetitious pattern.
- Commitment to treatment by infidel.
- Different levels of commitment.
- Noninvolved spouse tolerates affair.
- Ambivalence to stay or end the marriage.
- Own feelings versus client's values.
- Avoiding triangulation by couple.
- Homosexual affair in hetero marriage.
- Dealing with pain/anger/revenge.
- Differing stages of recovery.
- Attitude of society about affair.
- Help to understand meaning of affair.

In the same study, Brandt (1992) asked a similar question to the one being asked in this study. Her question was "How do you handle the issue of secrets and confidentiality when the nonparticipating spouse is unaware of the extramarital affair?" (p. 62). Following are the responses (in order from strongly agree to strongly disagree) given by the clinicians:

- Decide what to do case by case.
- Evaluate motives for revealing.
- Evaluate effect of disclosing the affair.
- Discourage secrecy/explore issue.
- See affair as resistance to intimacy.
- Suggest disclosure for personal growth.
- Encourage couple to disclose suspicion.
- Honesty/disclosure not always best.
- Never tell noninvolved spouse.
- Refuse treatment if affair is ongoing.
- Keep confidentiality/work on marriage.
- Affair ends/do conjoint work/keep secret.
- Individual treatment with refusal to end affair.

- Infidel to reveal or predict treatment failure.
- Put time limit on secrecy.

The dilemma most emphasized in this study is the one surrounding the issue of confidentiality and disclosure. What does a clinician do when he/she or his/her client either knows or suspects an affair? Is it essential to tell? Can the secret be buried and not addressed? When should the secret be disclosed? By whom? When is it best not to disclose?

The Code of Ethics of AAMFT (2001) is unambiguous that confidentiality not be violated during psychotherapy—many dilemmas can emerge when the boundaries of the therapeutic relationship are not clearly delineated. The clinician can actually become triangulated in the deceit and in the management of the aftermath of discovery.

This study asks clinicians what they actually do when faced with secrets relating to hidden affairs, especially as related to confidentiality, issues of safety, and issues relating to conflict of interest and dual relationships (AAMFT, 2001; Gladding, Remley, & Huber, 2001; Kitchener, 2000).

Closing Statement

The above literature review has painted a broad picture of the infidelity information available to clinicians. This researcher's intent was to place the clinical work of infidelity in the context of its larger system of couples therapy, and in social and historical contexts, and to expose the reader to the myriad of typological models on infidelity, and to the research literature available on attitudes, prevalence rates, gender differences, treatment issues and interventions, and to the many dilemmas and layers of complexity present in working with a population of clients who require much care and understanding. The literature review, and this study in general, were intended to provide

information that, whether first learned or learned anew, would enable the reader to feel more competent, knowledgeable, and skilled as a clinician facilitating the amelioration of clients' lives.

CHAPTER 3
METHODOLOGY

Introduction

The need for, and the potential benefit of, identifying the practices of therapists and counselors (clinicians) in treating infidelity and betrayal are clearly inferable from the professional literature (Brown, 1991; Pittman, 1983, 1987). Clinicians working with clients who are dealing with an affair or an affair's related dynamics have a challenging job (Brown, E., 1991, 1999; Glass, 1998, 1999, 2003a; Glass & Wright, 1988, 1997; Lusterman, 1995, 1998; Rhodes, 1984; Staheli, 1995).

As couples therapy evolves (Jacobson & Gurman, 1995a; Gurman & Jacobson, 2002; Johnson & Lebow, 2000), the collection and publication of information on current practices related to the treatment of this difficult and troubled population will better enable clinicians (irrespective of professional orientation) to make effective therapeutic judgment-calls. And such information will likely enable clinicians to meet their own needs for collegial professional consultation and for sharing key information with others who are also striving and sometimes struggling to facilitate therapeutic progress and growth in their clients.

Part of this study was originally designed to create a questionnaire, the Infidelity Perspective Survey (IPS), containing a scale (IPS-T) with three sub-scales (IPS-1, IPS-2, and IPS-3), that measured a clinician's overall tendency to promote infidelity disclosure in the treatment process of couples therapy, as well as that tendency when the affair is

either emotional (IPS-1), sexual (IPS-2), or combination emotional-sexual (IPS-3). Changes in approach, however, were made following the gathering of expert opinion.

The modified study was designed (a) to create a questionnaire, a final version of The Infidelity Perspective Survey (IPS: Appendix B) that contains a scale that measures a clinician's tendency to promote the disclosure of an affair (IPS = Infidelity Perspective) in the treatment process of couples therapy; (b) to use the IPS questionnaire to gather and report the actions clinicians take when faced with the context of several dilemmas, where the clinicians have knowledge or suspicion that a secret affair exists in the relationship of the couple they are treating or are about to treat; and (c) to analyze and determine the effects of gender, of clinical/professional experience with infidelity, of personal experience with infidelity, and of family of origin history with infidelity, on the clinician's tendency to promote the disclosure of affairs as part of couples therapy.

The study unfolds in four stages. Stage one includes the initial creation of the IPS and the ICD-Q items. Stage two involves validating the content of the IPS and the ICD-Q. Stage three is the Pilot Study. And, stage four is the main study.

Scope and Limitations of the Study

This study examines the current practices of clinicians regarding the disclosure of affairs as part of the therapy process in the treatment of infidelity. The first stage in the initiative was to have yielded a questionnaire containing a scale that measures how directive clinicians are in promoting the disclosure of affairs as part of the treatment process in couples therapy. This score for each questionnaire respondent measures the extent to which he/she promotes the disclosure of an affair as part of the process of treating infidelity in couples therapy (IPS score).

The second questionnaire, The Infidelity–Clinician Demographic Questionnaire (I-CDQ) (Appendix C), also part of stage one, was designed to gather background information on participating clinicians. All of the I-CDQ information is used to describe the sample of clinicians participating in the study. Some of the information is used to describe the independent variables and some will remain available for further analysis in subsequent research initiatives and/or subsequent reports.

By completing the IPS, clinicians have an opportunity to examine and assess their own beliefs and practices concerning how to approach the secret of infidelity and its disclosure during therapy, and can better question their standing on whether they bring unproductive, inhibiting biases and practices to their work. This more differentiated approach to therapy (I/E = Intellect over Emotions; Bowen, 1978) by a clinician can result in a less judgmental and less reactive tactic when dealing with the emotionally charged issue of infidelity.

The IPS, then, serves not only to survey the practices of clinicians regarding infidelity and its disclosure in therapy, but to stimulate the thinking of the clinicians who read and complete it. The questionnaire items describe real-life situations (and clinical dilemmas) that are regularly presented in the therapy room. A respondent's thinking about the circumstances of each scenario can be conducive to new learning and new applications.

Following the validation of the instrument, the piloting process, and the actual study, the results will become part of the public domain of the clinical community (professional stakeholders in psychotherapy). The information may prove useful in a number of arenas—from treatment-planning, teaching, and training, to writing and personal development.

Through the examination of the impact of gender, clinical/professional experience with infidelity, personal experience with infidelity, and family of origin history with infidelity on the respondents' (clinician's) tendency to promote disclosure of affairs as part of couples therapy, clinicians will have the opportunity to examine the personal biases they bring into the therapy room when doing this work.

Although this study is an in-depth look at telling practices of clinicians regarding secrets of infidelity in the therapy room, the study addresses only ongoing affairs, and not affairs that occurred in the past (whether recent or ancient) in the course of the couple's relationship history.

Additionally, despite the fact that the survey participants hold diverse academic degrees, come from a variety of clinical orientations, and are otherwise multicultural, all are members of one specific professional organization (AAMFT), and so may have homogenous characteristics that render them unique in the clinical community.

Notwithstanding the commonality of AAMFT membership, many of those surveyed are also members of other professional organizations and have, accordingly, perspectives influenced by other areas of the clinical community.

Despite these limitations, it is the intention of this researcher that the results of this study be informative and useful to clinicians belonging to all professional organizations, and that the literature review appearing in Chapter 2 advance the integration of information on infidelity from all the various disciplines that strive to help clients improve the quality of their lives through recovering and growing from traumatic, painful events such as infidelity.

A final wish of this researcher is that this study reach clinicians by shining additional light on the very challenging work clinicians undertake when they work with

infidelity and trauma, and that the study empower them through the information presented here to do better, learn more, and feel validated for what they are already doing.

The use, at this time, of the qualitative information that emerged from the study is being limited to only a summary and a cursory mention in this writing. It perhaps will be useful for further research or for other endeavors at a later date.

Participants

The Population and the Sample

The population under study is clinicians who are members of the AAMFT professional association. The AAMFT is an organization that was founded in 1942. Members include mental health professionals who diagnose and treat mental illness, emotional disorders, and health and behavioral difficulties in the family system.

Clients treated by AAMFT members typically present to therapy with a variety of problems, such as substance abuse, eating disorders, stress, anxiety, depression, marital and relationship issues, domestic violence, divorce, child/adolescent issues, parenting difficulties, blended family issues and an array of other difficulties.

AAMFT members work in inpatient facilities, private practice, agencies, businesses, research establishments, schools, and universities. The membership is composed of 69% female (N = 13, 435) and 31% male (N = 4, 925).

According to Infocus Data Card organization, AAMFT is made up of 21,510 active paid members in the United States. Membership types include clinical members (N = 13, 363); clinical supervisors (N = 2, 613); affiliates (N = 947); students (N = 4,213); and associates (N = 1,725).

Clinical members are those clinicians who, in addition to academic training from an accredited institution, have undergone a minimum of 300 hours of supervised clinical practicum during their graduate program, have experience with at least 1000 hours of direct client contact, and have accumulated 200 hours of supervision. All approved supervisors are clinical members.

The AAMFT is representative of professionals holding a variety of advanced academic degrees, including Ph.D. (N = 3,219); M.S.W. (N = 1,171); M.S. (N = 3,146); M.Ed. (N = 853); M.A. (N = 5,055); Ed.D. (N = 572); and D.Min. (531). This variety of perspectives on clinical issues enhances the level of generalizabilty of this study to other professions.

For this study, the sample was derived from a sampling frame composed of members of AAMFT who are clinical members or clinical supervisors in the organization (Total N = 16,076).

AAMFT engages the organization Infocus Data Card, Inc. to provide services to those interested in accessing the AAMFT mailing list. For a fee, the INFOCUS staff, by use of its computerized process, draws random samples from the AAMFT list of members. This was done for both the pilot and the main study sampling portions of the work. Samples of N = 250 and N = 1000 were requested and obtained.

A sample of 250 clinicians was drawn from the AAMFT clinical members and approved supervisors mailing list database. A response rate of 20% was anticipated so that the sample size in the pilot study would be 50 people (large enough to address reliability and validity issues).

A sample of 1000 AAMFT members was randomly drawn from the AAMFT clinical members and approved supervisors mailing list database. A response rate of 20% was anticipated or 200 responses.

Sampling Procedures

Pilot and Main Study

The AAMFT list of clinical members and approved supervisors was used as the sampling frame. A computerized system was used where the names were organized by zip codes. Names were drawn according to the "nth" system (16t and 65th for the pilot and main study, respectively). The computer first created a list of names (N=250) for the pilot study mailing list, and then, reshuffled the remaining names and drew another sample (N = 1000). Both times, the names were drawn by programming the computer to select names (based on zip codes), with equal periods between them. This procedure is executable by any database software (MS Access, Paradox, Dat, MS Excel). This procedure was performed by the company that manages the mailing list for AAMFT, for a fee.

Procedures

Similar procedures were used for both the pilot study and the main study of this research initiative. Responses for each were collected in a post office box especially secured for the purpose of this research project, and accessible only to this researcher.

Pilot Study

A sample (N = 250) was randomly drawn from the AAMFT clinical members mailing list by the INFOCUS Organization. A packet containing a cover letter that served as an invitation to participate, an explanation of the project, and the informed consent form, was sent to the pilot sample (Appendix A). The packet also contained the IPS and the ICD-Q questionnaires, as modified following the integration of expert opinion (Appendices E and F), and a preaddressed, prestamped envelope. Two weeks

thereafter, the pilot sample was mailed a reminder preprinted post card, encouraging the perspective participants to complete and return the questionnaires (Appendix D).

Sixty questionnaire packets were returned. Thirty-seven were used in data analysis. Thirteen were discarded due to missing data, and 10 were discarded due to late arrival. Following data analysis, final versions of the IPS and the ICD-Q were produced.

Main Study

A sample (N = 1000) was randomly drawn from the AAMFT clinical members mailing list by the INFOCUS Organization. A packet containing a cover letter that served as an invitation to participate, an explanation of the project, and the informed consent form, was sent to the sample in the main study. The packet also contained the IPS and the ICD-Q questionnaires, as modified following the integration of information derived from the pilot study (Appendices B and C), and a preaddressed, prestamped envelope. Two weeks thereafter, the main study sample was mailed a reminder preprinted post card, encouraging the perspective participants to complete and return the questionnaires (Appendix D).

Two hundred-seventy questionnaire packets were returned. Two hundred twenty-seven were utilized for data analysis. Forty-three were discarded or disregarded due to missing data or late arrival.

Research Design

Factorial Investigation and Variables

This investigation is a between-subjects four-factor design (2x2x2x2). The four factors (each containing two levels), also called the independent variables (IV), are Gender (G); Clinical/Professional Experience with Infidelity (CEI); Personal Experience with Infidelity (PEI); and Family of Origin History with Infidelity (FOHI).

Following are the factors listed with their respective number of levels: IV1: Gender (Level 1: Male, Level 2: Female); IV2: CEI (Level 1: Low, Level 2: High); IV3: PEI: (Level 1: Yes, Level 2: No): and IV4: FOHI (Level 1: Yes, Level 2: No). The dependent variable (DV) is the IPS score for each of the respondents (clinicians).

Research Questions

The study is guided by the six research questions listed below:

- **Research Question 1**: Does the IPS validly and reliably measure a clinician's tendency to promote the disclosure of affairs as part of couples therapy?
- **Research Question 2**: What is the effect of gender (G) on a clinician's tendency to promote the disclosure of affairs as part of couples therapy?
- **Research Question 3**: What is the effect of clinical/professional experience with infidelity (CEI) on a clinician's tendency to promote the disclosure of affairs as part of couples therapy?
- **Research Question 4**: What is the effect of personal experience with infidelity (PEI) on a clinician's tendency to promote the disclosure of affairs as part of couples therapy?
- **Research Question 5**: What is the effect of family of origin history with infidelity (FOHI) on a clinician's tendency to promote the disclosure of affairs as part of couples therapy?
- **Research Question 6**: Are there any two-way interactions involving combinations of the levels of gender, CEI, PEI, & FOHI on a clinician's tendency to promote the disclosure of affairs as part of couples therapy?

Instrumentation

In order for this investigation to take place, a new tool needed to be created. The IPS and the ICD-Q were developed in anticipation of conducting the main part of this study. Following is a description of the development of the scale as well as the process employed to arrive at the ability to use the IPS and the ICD-Q with adequate levels of reassurance that the designed instruments provided adequate measuring capabilities.

Scale Development

Initial Development

The original draft of the Infidelity Perspective Survey (IPS) contained 11 common dilemmas in therapy. Each dilemma was followed by several second-person items. Each group of items was presented three times, differentiated by type of affair (i.e., emotional, sexual, combination emotional-sexual). Responses were requested using a 4-point Likert scale ranging from "Never" to "All of the time."

The items (practice options) were developed from a review of relevant literature on existing theories and suggested treatment interventions for clients dealing with an affair (Brown, 1991: Glass, 2002, 2003b; Glass & Wright, 1977, 1985,1988,, 1999; Lusterman, 1989, 1995, 1998; Pittman, 1987).

Additionally, the product was the result of intensive, multiple-rounds of brainstorming sessions and edification times that included this researcher and her doctoral committee chair—both licensed professionals, clinical members of AAMFT, with varying levels of expertise in the area of relationship therapy (Crawford & Upchurch, 1999; Echevarria-Doan, 2001; Rafuls, 1994; Rafuls & Moon, 1994). In addition to content, the questions were reviewed for sequencing, wording, clarity, completeness, meaning, and syntactical accuracy.

The original draft of the Infidelity–Clinician Demographic Questionnaire (I-CDQ) contained demographic items, as well as the following three subscales: (a) Clinical/professional Experience with Infidelity (CEI); (b) Professional History with Infidelity Which Included Personal Experience with Infidelity (PEI) and Family of Origin History with Infidelity (FOHI); and (c) Personal Beliefs.

Demographic items included gender, age, race, marital status, religious affiliation, political party affiliation, political leaning, religious leaning, level of religiosity/spirituality, academic degrees earned, licensures held, professional affiliations, specialized training received/certifications, years in practice, focus of work, treatment model orientation, and number of couples treated in career. The CEI contained 1 item pertaining to approximate number of cases involving infidelity, 10 items pertaining to the focus of work with infidelity (measured using a 3-point Likert scale ranging from Never to Most of the time), 4 items pertaining to the effects of disclosure (measured using a 3-point Likert scale ranging from Never to Most of the time), 14 items pertaining to present practices based on effects of disclosure (measured using a 4-point Likert-scale ranging from Never to All of the time), 5 items specifically addressing disclosure attitudes (measured using a 4-point Likert scale ranging from Never to All of the time), and 30 items pertaining to effects following disclosure (measured using a 3-point Likert scale ranging from Never to Most of the time).[1] The PEI consisted of 6 items requesting responses by checking one of three boxes (i.e., No, Yes–openly, or Yes–secretly).[2] The FOHI consisted of 18 items[3] measured using a 4-point Likert Scale (i.e., No, not to my knowledge, Suspect so, Know so, Don't know). Two additional items requested lifetime number of sexual partners and sexual orientation. The Personal Beliefs subscale consisted of 16 items measured using a 4-point Likert scale ranging from Never to All of the Time.

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[1] These last 30 items requested a second response pertaining to impact.

[2] The 6 items were subdivided into 3 items regarding current personal experience (PEI-C) and 3 items regarding past personal experience (PEI-P).

[3] There were six items targeted at a specific familial member (e.g., paternal grandfather). Each of these items requested three responses (e.g., betraying partner, betrayed partner, other man/woman)

IPS Final Version: Response Style and Item Scoring

The final version of the IPS is a series of 11 questions (dilemmas). Additionally, the 11 questions contain a total of 62 items. Each of the 11 dilemma questions contains between 4 and 14 items that are rated by the respondent on a 4-point Likert-Scale. Each of the 62 items is a closed-ended question. The closed-ended questions offer four choices of response: 1 = Never or Almost Never; 2 = Some of the time; 3 = Most of the time; and 4 = All of the time.

Together, the 4 to 14 items under each of the 11 dilemmaquestions describes, in the context of the scenario set forth in the question, a particular proposed practice action bearing on the issue of disclosing or not disclosing an affair. Further, each of the 11 questions provides an opportunity for an open-ended qualitative response to a solicitation for "other" information. The respondent may write-in any response that is representative of what he/she does under the circumstance described in the scenario it addresses.

The 62 items were each processed for directional accuracy with regard to the intent of that item (no tendency to maximum tendency to disclose). Within each of the 11 dilemmas, anywhere from 1 to 4 items were found to need inversion when scored so that they would remain true to the intent of the survey (do you tell, not tell, or do nothing?).

Specifically, items 1e, 1f, 2b, 2c, 2d, 3b, 3c, 3e, 4d, 5a, 6b, 6k, 6l, 6m, 6n, 7a, 7c, 7d, 7e, 7f, 8a, 8d, 9a, 9d, 10a, 10b, 10f, 11b, 11d, and 11e were designated as needing inversion when scored (therefore: 1 = 4, 2 = 3, 3 = 2, and 4 = 1).

The sum of the responses provides a respondent's score of his/her Infidelity Perspective. The raw scores (ranging from 11 to 228) will not be reported in this initiative.

Expert Review

A group of experts (n = 11, convenient sample) was assembled to review the IPS and the ICD-Q both qualitatively and quantitatively. The meeting, called "Consensus Group Meeting," was held at a private gathering at a restaurant in central Florida. Dinner was served as a motivator and a thank you for participation and attendance.

The highest levels of education of the group members were Doctor of Philosophy (n = 4); Master of Social Work (n = 1); Doctor of Philosophy candidates (N = 2); Education Specialist (n = 1); Master of Science (n = 3). All but two of the group members are practicing clinicians. Two work full time as psychology professors at a local university. Two of the group members are licensed psychologists; one is a Christian counselor; one currently works as a financial advisor; five are licensed Marriage and Family Therapists, and one is a Marriage and Family Therapist intern. Seven are females and four are males. The facilitator was this initiative's researcher (female, Doctor of Philosophy candidate, and licensed Marriage and Family Therapist in private practice).

The participants' willingness and commitment to participate was obtained via telephone. Each participant received by mail or hand-delivery a packet containing

- A cover letter of explanations and instructions (Appendix E).
- A copy of the description and goals of the study (Appendix E).
- A reminder sheet that included the tentative agenda for the evening.
- A copy of the cover letter that would be included in the pilot study (Appendix A).
- A copy of the original IPS and ICD-Q.
- A worksheet for them to use as they evaluated the instruments (Appendix F).

Guiding questions were brainstormed by the facilitator following recommendations in literature by Krueger (1998), Krueger and Casey (2000), and Morgan (1998). The meeting lasted 2 1/2 hours. Following the meeting, many of the

clinicians remained to socialize and become more acquainted with each other (a pleasant and unplanned networking opportunity).

The expert review session was videotaped for convenience. A note taker was also present to record comments and other observations. The process also included writing information on a flipchart so that comments could be reviewed and remembered accurately.

The expert review session prompted several changes to the scales. First, an IPS cover page that included an operational definition of "affair" was added. This resulted from the consensus opinion of the group that, for the most part, little difference existed in the responses to each of the three types of affairs. The members of the group advocated collapsing the three definitions of emotional affair, sexual affair, and combination emotional-sexual affair into one. Through a facilitated process, the group first brainstormed and then together adopted the components of the new, generic, global definition of "affair" used in the IPS instrument.

Second, the tense of the dilemmas was changed from present to past. Third, the Personal Beliefs subsection of the I-CDQ was moved to the IPS. Fourth, all items from the CEI section of the I-CDQ were moved to the IPS with the exception of the one item addressing the approximate number of cases involving infidelity and the ten FOHI items. Fifth, the PEI section of the I-CDQ was moved to the IPS. Sixth, demographic items were reorganized. This resulted in an I-CDQ with the following 5 subsections: (a) Professional Profile, (b) Work Profile, (c) Personal Data, (d) CEI, and (e) PEI/FOHI, and an IPS with the following 3 subsections: (a) Common Dilemmas in Therapy, (b) Personal Beliefs, and (c) Professional Practices with Infidelity (i.e., former CEI items).[4]

[4] All independent variables were now part of the I-CDQ, and the dependent variable was part of the IPS.

Pilot Study

The aforementioned draft of the scales was mailed to a random sample of 250 clinical members of AAMFT. The total number of timely returned surveys was 50. The total number of usable responses was N = 37 (Male = 13, Female = 24). Quantitative and qualitative analyses were used to determine the reliability and validity of the scales in order to inspire further revisions. The reliability statistics for all subscales are displayed in Table 3-1.

Table 3-1. Item-total statistics and reliability (pilot)

Test	M	SD	Item N	Sample N	Reliability
IPS	149.31	11.79	61	13	.73
CEI	18.21	2.62	10	34	.67
PEI	2.09	2.09	6	34	.56
FOHI	21.50	8.25	18	30	.94

IPS

Only the vignette responses were relevant to the present research. The responses to these 61 items yielded a Cronbach's alpha reliability coefficient of .73. Hence, the IPS was considered to be adequately reliable. Due to the length of the IPS, changes were based on qualitative comments from the expert review session. Item statistics are presented in Table 3-2.

CEI

The responses to these 10 items yielded a Cronbach's reliability coefficient of .67. Since the deletion of no one item would appreciably increase alpha, it was determined that reliability was adequate given the number of responses and the number of items on this subscale. Item statistics are displayed in Table 3-3.

Table 3-2. Item analysis statistics–IPS (Pilot)

Item	M	SD	Corrected Item-total correlation	Alpha if Item deleted
1	2.00	1.29	0.13	0.7259
2	2.69	1.11	-0.12	0.7386
3	1.00	0.00	0.00	0.7256
4	1.31	0.48	0.27	0.7204
5	2.54	0.97	0.02	0.7296
6	3.77	0.44	-0.25	0.7318
7	1.46	0.52	-0.10	0.7294
8	2.08	0.49	0.23	0.7212
9	3.62	0.65	0.39	0.7149
10	3.69	0.63	0.51	0.7113
11	1.69	0.75	0.28	0.7179
12	3.62	0.51	0.40	0.7166
13	3.00	0.91	0.71	0.6967
14	2.31	0.95	-0.16	0.7377
15	3.46	0.66	-0.06	0.7299
16	2.46	0.97	-0.19	0.7392
17	2.31	0.75	0.25	0.7192
18	1.85	0.90	-0.32	0.7437
19	3.77	0.44	0.50	0.7155
20	3.31	1.03	0.62	0.6985
21	2.15	0.90	0.06	0.7271
22	1.85	0.80	0.12	0.7244
23	1.77	0.73	-0.30	0.7388
24	3.08	0.76	0.63	0.7042
25	2.08	0.76	-0.59	0.7499
26	1.46	0.52	0.12	0.7238
27	1.31	0.48	-0.12	0.7295
28	3.62	0.65	-0.08	0.7304
29	3.46	0.97	0.11	0.7252
30	3.62	0.65	0.36	0.7160
31	2.85	0.99	0.14	0.7240
32	1.38	0.65	0.22	0.7205
33	1.69	0.75	0.49	0.7099
34	3.15	0.90	0.71	0.6967
35	3.62	0.51	0.83	0.7054
36	1.85	0.80	-0.04	0.7303
37	3.15	0.69	0.67	0.7045
38	3.54	0.88	0.09	0.7259
39	1.77	0.93	-0.08	0.7336
40	1.62	0.65	-0.39	0.7399
41	2.23	1.01	0.38	0.7115
42	3.62	0.65	0.21	0.7208
43	2.62	1.19	0.70	0.6897
44	1.85	0.80	0.55	0.7065
45	2.31	0.85	0.32	0.7156

Table 3-2. Continued

Item	M	SD	Corrected Item-total correlation	Alpha if Item deleted
46	3.08	0.64	0.04	0.7264
47	3.38	0.65	0.27	0.7190
48	2.92	0.95	0.44	0.7090
49	2.69	0.85	0.27	0.7181
50	1.31	0.48	-0.06	0.7282
51	3.69	0.48	0.41	0.7169
52	2.85	1.14	0.13	0.7254
53	2.62	1.33	0.26	0.7176
54	1.54	0.88	0.14	0.7237
55	1.38	0.65	0.26	0.7194
56	1.23	0.60	0.32	0.7178
57	1.23	0.60	-0.06	0.7292
58	1.00	0.00	0.00	0.7256
59	2.92	1.38	0.15	0.7256
60	1.46	0.66	0.35	0.7163
61	2.46	1.27	0.06	0.7306

Table 3-3. Item analysis statistics–CEI (pilot)

Item	M	SD	Corrected item-total correlation	Alpha if Item deleted
1	2.09	0.45	0.41	0.64
2	2.41	0.56	0.11	0.69
3	1.53	0.51	0.11	0.69
4	1.29	0.46	0.21	0.67
5	2.24	0.55	0.35	0.65
6	2.00	0.49	0.59	0.60
7	1.76	0.50	0.57	0.61
8	1.56	0.50	0.32	0.65
9	1.76	0.55	0.41	0.63
10	1.56	0.61	0.35	0.65

PEI

The responses to these six items yielded a Cronbach's alpha of .56. This was most likely due to the small number of items. However, the first three items displayed zero item-total correlations. Although this is also artificially affected by the small number of items, its contrast to the other three items provides discriminative validity between the notion of two constructs—past and present experience with infidelity. Furthermore, the cause of the zero item-total correlations was the fact that all responses

were "No" to these three items. It was decided that these past and present items would be retained as collapsed and reinspected after obtaining results to the actual study with a larger sample size. Item Statistics are displayed in Table 3-4.

Table 3-4. Item analysis statistics–PEI (pilot)

Item	M	SD	Corrected item-total correlation	Alpha if Item deleted
1	0.00	0.00	0.00	0.59
2	0.00	0.00	0.00	0.59
3	0.00	0.00	0.00	0.59
4	0.76	0.92	0.66	0.26
5	0.76	0.89	0.43	0.46
6	0.56	0.82	0.49	0.41

FOHI

The responses to these 18 items yielded a Cronbach's alpha of .94. Although the first item displayed poor discrimination, its inclusion was substantively necessary. This subscale was considered to be adequately reliable. Item statistics are displayed in Table 3-5.

Table 3-5. Item analysis statistics–FOHI (pilot)

Item	M	SD	Corrected item-total correlation	Alpha if Item deleted
1	1.17	0.53	0.07	0.95
2	1.27	0.64	0.77	0.94
3	1.10	0.40	0.21	0.95
4	1.37	0.72	0.63	0.94
5	1.10	0.40	0.03	0.95
6	1.20	0.66	0.71	0.94
7	1.20	0.66	0.73	0.94
8	1.43	0.97	0.71	0.94
9	1.17	0.65	0.77	0.94
10	1.13	0.57	0.81	0.94
11	1.13	0.57	0.94	0.94
12	1.10	0.55	0.87	0.94
13	1.40	0.97	0.74	0.94
14	1.10	0.55	0.87	0.94
15	1.10	0.55	0.87	0.94
16	1.30	0.75	0.72	0.94
17	1.10	0.55	0.87	0.94
18	1.13	0.57	0.81	0.94

Final Version of Survey

Based on the results of the expert review session, the pilot study, and consultation, a final version of the survey was produced. This version can be found in Appendix B.

CEI

A median split of the sum of the responses was used to categorize participants as either low or high in experience with clinical/professional experience with infidelity.

PEI

Any response of "Yes – Openly" or "Yes – Secretly" was used to categorize the response as Yes.

FOHI

A sum score of zero resulted in a categorization of no family of origin history with infidelity. A median-split was then used with sum scores greater than zero to categorize participants as having either high or low family of origin history with infidelity.

Data Analysis (Main Study)

In addition to a descriptive analysis of the data, a four-way between-subjects ANOVA is used to test for significant two-way interaction and simple main effects. The qualitative data derived from the write-in responses on the IPS is reported in its raw form. Table and graphs are included.

CHAPTER 4
DATA ANALYSIS AND RESULTS

Introduction and Overview

Chapter 4 presents the data obtained in the main study of this research initiative. It includes both descriptive and inferential statistics derived from data analysis, referred to in more detail below. The chapter is divided into six sections. Section one is the introduction and overview. Section two includes the descriptive statistics of the sample demography (including the independent variable of gender). Section three covers the data pertaining to the dependent and independent variables (IPS, CEI, PEI, FOHI, excluding gender). Section four is information about the final version of the survey, including the reliability of the IPS, CEI, PEI, and FOHI scales. Section five pertains to the results of the main study (both the quantitative and qualitative data). And, finally, section six is a summary of the results presented in this chapter.

The purpose of this study was to determine the influence of therapists' and counselors' gender, and clinical/professional experiences, personal experiences, and family of origin history with infidelity, on their tendency to promote the disclosure of affairs as part of couples therapy. In order to achieve the goal, a variety of steps were taken.

Following the construction of an instrument to collect demographic data (the ICD-Q), a measuring instrument to measure infidelity perspectives (the IPS) was designed. Both the ICD-Q and the IPS were validated. The instruments were piloted

(following expert opinion feedback), and the study was conducted. The data pertaining to the creation of the instruments (including expert feedback and the pilot study results) was presented previously in Chapter 3 of this dissertation as part of the methodology leading to the actualmain study investigation. So this chapter reports the results of the main study investigation only.

One thousand surveys (I-CDQ and IPS) were disseminated, of which 270 were returned. Of the 270 returned, 227 were included in the final analysis. Forty-three were excluded from the analysis because key data was missing from parts or all of one or both questionnaires. The response rate in the main study of this initiative (27%) was larger than that of the pilot study (24%).

Following are descriptive statistics performed on the sample in the study. The data reported in the narrative descriptions reflects numbers that are rounded to the nearest tenth. The data includes statistics pertaining to the sample's age, gender, race, highest degree earned, licensures held, professional affiliations, specialized training and certifications, focus of work, treatment model orientation, religious affiliation, marital status, religious/spiritual leaning, political party affiliation, political leaning, self-described religiosity/spirituality, lifetime number of sexual partners, sexual orientation, approximate number of infidelity cases in career, work populations, and number of couples treated.

Subsequent data reports descriptive and inferential statistics pertaining to the analysis of information vis-à-vis the IPS (overall), the independent variables (G, CEI, PEI, & FOHI), and the final version of the IPS (reliability and validity). The final part of the chapter includes the data (quantitative and qualitative) collected and/or analyzed for the main study of this investigation.

Descriptives (Sample Demography)

The ages of those people included in the study ranged from 31 to 85 years (M = 56.57, SD = 9.79), and the number of years in practice ranged from 0 to 60 (M = 19.4, SD = 9.70).

Table 4-1 displays the frequencies for gender and race. The sample consists of 227 participants, approximately 1/3 of whom were men (N = 71), while the rest were women (N = 155). Approximately 89% were White, and the remaining participants were distributed across Blacks (3%), Asians (.5%), others (1%), and no response (6%).

Table 4-1. Frequencies for gender and race

Variable	Frequency	Percent
Gender		
Male	71	31.3
Female	155	68.3
No response	1	0.4
Total	227	100.0
Race		
White	203	89.4
Black	7	3.3
Asian	1	0.5
Other	3	1.4
No response	13	5.7
Total	227	100.0

Table 4-2 displays the frequencies of the highest degrees earned by the respondents. The most frequently occurring academic degree was a masters (59%), followed by a doctoral (31%), and other (10%).

Table 4-2. Frequencies for highest degree earned

Degree	Frequency	Percent
Masters	133	58.6
Doctoral	71	31.3
Other	23	10.1
Total	227	100.0

Table 4-3 compares the results of the demographics of the AAMFT population with those of the sample in three dimensions. The data highly suggests that the sample is representative of the population in at least two of these three dimensions (Gender and Degrees Held). It is notable that on the gender dimension, the AAMFT population is made up of 31% male members, the same percentage of male participants in the sample (31%). Similarly, the number of females in the AAMFT population is 69%, while the number of females in the sample is 68%.

Table 4-3. Comparison of AAMFT population and main study sample

Item	AAMFT population	Study sample
Number (N)	15,976 (100%)	227 (100%)
Gender		
Males	4,953 (31%)	71 (31%)
Females	11,023 (69%)	155 (68%)
Degrees held		
Doctorals (Ph.D./Ed.D./D.Min)	4,322 (27%)	71 (31%)
Masters (M.S./S.M.W./M.Ed./M.A.)	10,825 (67%)	133 (59%)
Other	829 (5%)	23 (10%)
Clinical members	13,363 (84%)	158 (70%)
Approved supervisors	2,613 (16%)	69 (30%)

Notable too is the comparison between the population and the main study sample vis-à-vis the highest degree held by the clinicians. In the population, 27% hold doctorate degrees, while in the sample, 31% hold doctoral degrees. Those holding masters degrees in the AAMFT population total 67%, while in the sample, those holding masters degrees total 59%. A larger percent of the sample (30%) hold Approved Supervisor Status than does the AAMFT population (16%).

Table 4-4 displays the frequencies of licensures held by the respondents. The sample consisted of licensed professionals, many of whom hold more than one license.

The majority of participants hold a Marriage and Family Therapy license (86%), while the rest were distributed across licenses of Mental Health Counselor (23%), Clinical Social Worker (13%), Psychologist (12%), Pastoral Counselor (7%), and Christian Counselor (4%).

Table 4-4. Frequencies for licensures held

Licensure	Frequency	Percent
Psychologist	27	11.9
Marriage & Family Therapist	195	85.9
Mental Health Counselor	52	22.9
Clinical Social Worker	29	12.8
Pastoral Counselor	16	7.0
Christian Counselor	9	4.0
Medical Doctor	0	0.0
Other	32	14.1

Table 4-5 displays the frequencies of respondents' professional affiliations. Of the 227 clinicians, all were members of AAMFT (100%). Some belonged to other associations: Other (28%), American Psychological Association (12%), American Counseling Association (12%), National Association of Social Workers (11%), National Association of Professional Counselors (7%), National Association of Christian Counselors (6%), and National Association of Mental Health Counselors (3%).

Table 4-5. Frequencies for professional affiliations

Licensure	Frequency	Percent
AAMFT	226	99.6
APA	27	11.9
NASW	25	11.0
ACA	26	11.5
NAMH	7	3.1
NACC	13	5.7
NAPC	16	7.0
Other	64	28.2

The sample group included clinicians with a variety of a single or a combination of specialized training. Table 4-6 displays frequencies of respondents' specialized

training and certifications. Of the 227 participants, 1/3 were AAMFT Approved Supervisors (N=69), with the rest occurring as follows: Solution Focused Therapy (N = 90), Other (N = 71), Trauma (N = 52), Alcohol/Addictions (N = 49), Grief (N = 47), Sex Therapy and Sex Educator (N = 29 and N = 11 respectively), Emotion Centered Therapy (N = 26), Imago Relationship Therapy (N = 18), Passionate Marriage/Crucible (N = 13), Gottman Therapist (N = 12), Hot Monogamy (N = 5), and Mars & Venus (N = 4).

Table 4-6. Frequencies for specialized training and certifications

Specialized training and certifications	Frequency	Percent
Sex therapist	29	12.8
Sex educator	11	4.8
Imago relationship therapist	18	7.9
Gottman therapist (Sound marital house)	12	5.3
Mars & Venus	4	1.8
Passionate marriage (crucible)	13	5.7
Hot monogamy	5	2.2
Emotion centered	26	11.5
Solution focused	90	39.6
Alcohol/addiction counselor	49	21.6
Trauma counselor	52	22.9
Grief counselor	47	20.7
AAMFT approved supervisor	69	30.4
Other	71	31.3

Tables 4-7 and 4-8 address information pertaining to the respondents' focus of work and their treatment model orientation. Table 4-7 illustrates that the clinicians in the study focus time on a variety of activities during their work. Of the participants answering this question (N = 219), and other than spending time in direct client care, some of the clinicians never (0%) engage in research (N = 75), academic teaching (N = 53), training (N = 22), providing supervision (N = 45), administration (N = 32), or Other (N = 28).

All of the participants spend time during their work focusing on direct client care. The statistics illustrate that no people (N = 0) spend 0% of time focusing on direct client care (implying, therefore, that they spend some time in delivering direct client care). Of the 219 people responding, approximately 75% (N = 157) spend between 61% and 100% of their time in this activity. A small number of respondents (N = 5) spend between 41% and 100% of their time conducting research.

Respondents indicated various frequencies of utilizing different treatment models. Responses were made using a 4-point Likert scale ranging from "Never or almost never" to "All of the time." Means and standard deviations for each treatment model are provided in Table 4-8. The results suggest that therapists are using a wide variety of techniques and are not relying on one technique alone.

Table 4-7. Frequencies for focus of work (approximate percent of time spent)

Focus of work	0%	1% to 20%	21% to 40%	41% to 60%	61% to 80%	81% to 100%
Research	75	55	7	3	1	1
Client care (direct)	0	24	17	21	57	100
Academic teaching	53	50	18	11	7	2
Training (workshops, etc.)	22	103	19	6	2	0
Providing supervision	45	79	26	8	2	0
Administration	32	82	24	12	3	3
Other	28	19	2	4	0	1

Table 4-8. Means and standard deviations for treatment model orientation

Model	M	SD	n
Behavioral	1.93	.65	172
Cognitive/behavioral	2.46	.70	204
Cognitive	2.23	.70	168
Bowenian	2.03	.81	187
Structural	2.06	.72	175
Narrative	1.67	.72	171
Solution focused	2.34	.70	193
Medical	1.55	.71	168
Emotion focused	1.96	.80	175
Strategic	1.92	.71	178
Experiential	1.95	.78	170
Feminist	1.79	.81	165

Table 4-9 displays frequencies for respondents' religious affiliation. The sample included the majority (63%) of people reporting a Christian affiliation (N = 144), with 11% reporting a Jewish affiliation (N = 25), followed by 10% claiming no affiliation (N = 23). Some (6%, N = 14) provided no response, while 7% (N = 16) reported an "Other" affiliation.

Table 4-9. Frequencies for religious affiliations

Religious affiliation	Frequency	Percent
Buddhism	5	2.2
Christianity	144	63.4
Islam	0	0.0
Hinduism	0	0.0
Jewish	25	11.0
None	23	10.1
Other	16	7.0
No response	14	6.2
Total	227	100.0

Table 4-10 displays frequencies for the respondents' marital status. Of the 227 clinicians, 61% were married (N = 138), 11% were divorced (N = 25), 9% were divorced and remarried (N = 21), 6% offered no response (N = 13), 4% were single/never married (N = 10), 4% were in committed relationships/not living together (N = 8), 3% were widowed (N = 7), and 2% were in a committed relationship/living together (N = 5).

Table 4-10. Frequencies for marital status

Marital status	Frequency	Percent
Married	138	60.8
Divorced	25	11.0
Divorced and remarried	21	9.3
Widowed	7	3.1
Single/never married	10	4.4
In committed relationship (living together)	5	2.2
In committed relationship (not living together)	8	3.5
No response	13	5.7
Total	227	100.0

Table 4-11 displays frequencies for respondents' religious/spiritual leaning. The largest number of clinicians reported a liberal leaning (N = 112, 49%), followed by a

moderate leaning frequency of 26% (N = 59). Those reporting a conservative leaning included 37 people, representing 16% of the sample. Those clinicians leaning towards fundamentalism constituted 1% of the sample, or 3 people.

Table 4-11. Frequencies for religious/spiritual leaning

Religious/spiritual leaning	Frequency	Percent
Liberal	112	49.3
Conservative	37	16.3
Moderate	59	26.0
Fundamentalist	3	1.3
Other	6	2.6
No response	10	4.4
Total	227	100.0

Table 4-12 displays frequencies for respondents' political party affiliation. The majority affiliation for this sample was Democrat (58%, N=131), followed by Republican (23%, N=51), and then followed by Independent (13%, N=29). Other and those not responding included 7% of the people (N = 16).

Table 4-12. Frequencies for Political Party Affiliation

Political party affiliation	Frequency	Percent
Republican	51	22.5
Democrat	131	57.7
Independent	29	12.8
Other	5	2.2
No response	11	4.8
Total	227	100.0

Table 4-13 displays frequencies for respondents' political leaning. Of the 227 respondents, 42% (N = 95), 35% (N = 83), and 12% (N = 27) report leaning politically towards liberal, conservative, and moderate positions respectively. Ten percent, offered no response.

Table 4-14 illustrates the frequencies for the clinicians' self-descriptions of their religiosity and spirituality. The respondents indicate that a large number consider

themselves religious either some of the time, most of the time, or all of the time (32%, 20%, or 27%). Thirty-seven (16%) of the clinicians never consider themselves religious. With regard to spirituality, only 3% (N = 7) of those responding never consider themselves spiritual, while a large majority (N = 216) consider themselves spiritual either some of the time, most of the time, or all of the time. Two percent of the sample did not respond to this question.

Table 4-13. Frequencies for political leaning

Political leaning	Frequency	Percent
Liberal	95	41.9
Conservative	83	36.6
Moderate	27	11.9
No Response	22	9.7
Total	227	100.0

Table 4-14. Frequencies for self-description of religiosity and spirituality

Topic	Frequency	Percent
Consider myself religious		
Never	37	16.3
Some of the Time	72	31.7
Most of the Time	45	19.8
All of the Time	61	26.9
No Response	12	5.3
Total	227	100.0
Consider myself spiritual		
Never	7	3.1
Some of the Time	21	9.3
Most of the Time	50	22.0
All of the Time	145	63.9
No Response	4	1.8.
Total	227	100.0

Table 4-15 presents the descriptive data related to the lifetime number of sexual partners had by those responding to this question. Of the 227 respondents, 2% (N = 5) did not provide information to this question (no response). Of those responding, the largest number (N = 53 or 23%) reported between 6-10 lifetime partners. The next largest

number (N = 51 or 23%) reported only 1 lifetime partner. The remaining participants were distributed across more than 25 lifetime partners (N = 20 or 9%), 2 (N = 19 or 8%), 3 (N = 19 or 8%), 4 (N = 19 or 8%), 11 to 15 (N = 16 or 7%), 5 (N = 15 or 7%), 16 to 20 (N = 5 or 2%), 0 (N = 3 or 1%), and 21 to 25 (N = 2 or 1%).

Table 4-15. Frequencies for lifetime number of sexual partners

Lifetime Number of Sexual Partners	Frequency	Percent
0	3	1.3
1	51	22.5
2	19	8.4
3	19	8.4
4	19	8.4
5	15	6.6
6 to 10	53	23.3
11 to 15	16	7.0
16 to 20	5	2.2
21 to 25	2	0.9
More than 25	20	8.8
No Response	5	2.2
Total	227	100.0

Table 4-16 displays frequencies for the respondents' sexual orientation. The sample includes 93%, or 210 people, reporting heterosexual orientation, 3% or 6 people reporting a lesbian orientation, 3% or 6 people reporting a bisexual orientation, and 2% or 4 people reporting a gay orientation. One person did not respond to this question.

Table 4-16. Frequencies for sexual orientation

Sexual orientation	Frequency	Percent
Heterosexual	210	92.5
Gay	4	1.8
Lesbian	6	2.6
Bisexual	6	2.6
No response	1	0.4
Total	227	100.0

Table 4-17 displays frequencies for the approximate number of cases involving infidelity that the respondents have worked with. The majority of the clinicians in the

sample (57%) report having worked with 0-100 couples. Thirteen percent have worked with 201-300 couples, 12% have worked with 101-200 couples, 5% have worked with more than 500 couples, and 1% have worked with 401-500 couples. Four percent did not respond to this question. The data shows that the participants are experienced clinicians.

Table 4-17. Frequencies for approximate number of cases in career involving infidelity

Cases	Frequency	Percent
0–100	130	57.3
101–200	28	12.3
201–300	30	13.2
301–400	15	6.6
401–500	3	1.3
More than 500	12	5.3
No response	9	4
Total	227	100

Table 4-18 displays the populations with which these respondents work. A very high number of the clinicians have worked with individuals (96%), couples (94%), families (93%), and adults (92%). The clinicians also report working with adolescents (80%), children (55%), groups (45%), and geriatrics (44%). The frequencies resulting from data gathered on this question indicates that the participating clinicians tend to work with a variety of populations.

Table 4-18. Worked with populations

Population	Frequency	Percent
Couples	214	94.3
Individuals	217	95.6
Groups	103	45.4
Families	212	93.4
Children (age 0–12 years)	125	55.1
Adolescents (age 13–18 years)	181	79.7
Adults	209	92.1
Geriatrics	100	44.1
Other	3	1.3

Table 4-19 displays the number of couples treated in the respondents' careers. The responses are distributed as follows: 0-100 couples (N = 51), 101 to 200 (N = 42),

201 to 300 (N = 23), 301 to 400 (N = 19), 401 to 500 (N = 20). The total of those clinicians who have worked with between 501 and over 1000 couples in their careers is 65. Seven participants did not offer a response.

Table 4-19. Frequencies for number of couples treated in career

Number of couples	Frequency	Percent
0–100	51	22.5
101–200	42	18.5
201–300	23	10.1
301–400	19	8.4
401–500	20	8.8
501–600	8	3.5
601–700	8	3.5
701–800	4	1.8
801–900	4	1.8
901–1000	4	1.8
Over 1000	37	16.3
No response	7	3.1
Total	227	100.0

Independent and Dependent Variables

This research initiative included one dependent variable (the IPS score) and four independent variables (G, CEI, PEI, and FOHI). Table 4-20 displays the descriptive statistics for the four subscales in the study (IPS, CEI, PEI, and FOHI) and will be further referenced in each of the corresponding sections following.

Table 4-20. Descriptive statistics for scales

Scale	N	M	SD	Median	Categorization
IPS	227	2.52	0.24	2.53	None
CEI	193	17.70	2.76	18.00	Low = 83 High = 110
PEI	227	1.53	0.50	2.00	Yes = 106 No = 121
FOHI	222	1.46	0.50	1.00	Yes = 120 No = 102

IPS

The mean was used to summarize responses to the 4-point Likert scale (ranging from 1 = never or almost never to 4 = all of the time) ratings of vignettes on this subscale. Table 4-20 displays descriptive statistics for this subscale.

Figure 4-1 displays the mean responses to the IPS across the respondents. Figure 4-2 displays the rounded mean of the IPS responses for all subjects. Approximately 95 respondents had a mean response of "Some of the Time" (i.e., response 2), and approximately 130 respondents had a mean response of "All or Most of the Time" (i.e., response 3).

Figure 4-3 displays the mean IPS responses for all items. The figure shows the distribution of the 62 items that are part of the 11 dilemmas in the IPS and the number of mean responses for each of the items. For example, 10 items had a mean response of 3.75 (the response set provided in the IPS ranged from 1 = Never or Almost Never to 4 = All of the Time). In other words, when faced with the 11 dilemmas, and therefore the 62 items, on ten of the items, the clinicians responded with a mean score of 3.75 (out of 4) on those 10 items.

Figure 4-4 is a histogram of the mean IPS response for all items. However, now the mean has been rounded so that, when displayed, it makes clear that approximately 13 items had a mean response of "All of the Time" (i.e., response set option 4); 17 items had a mean response of "Most of the Time" (i.e., response set option 3); 28 items had a mean response of "Some of the Time" (i.e., response set option 2); and 4 items has a mean response of "Never or Almost Never" (i.e., response set option 1).

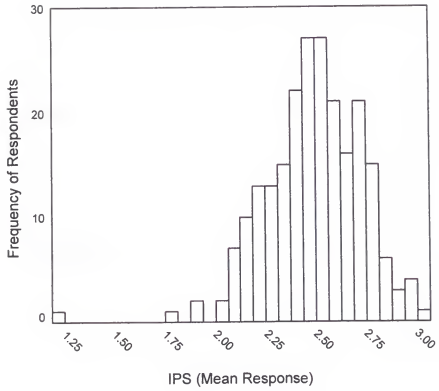

Figure 4-1. Histogram displaying the mean responses to the IPS across respondents.

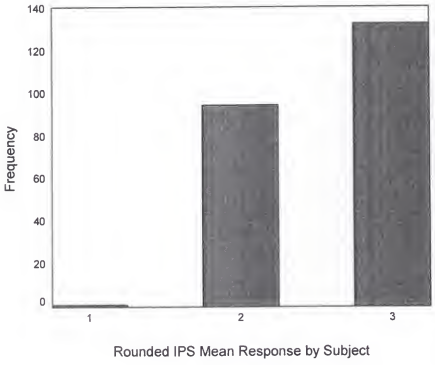

Figure 4-2. Histogram of the mean IPS response for all subjects

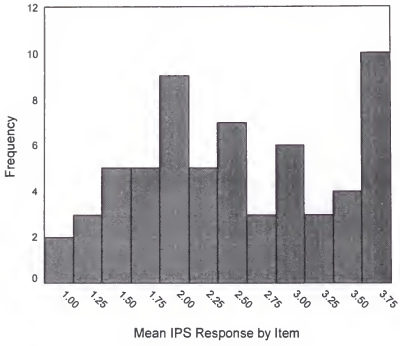

Figure 4-3. Histogram displaying the mean IPS responses for all items

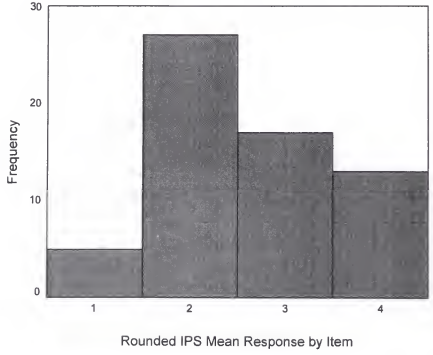

Figure 4-4. Histogram of the mean IPS response for all items

CEI

A median split of the sum of the responses was used to categorize participants as either low or high in experience with clinical/professional experience with infidelity.[1] Table 4-20 displays descriptive statistics for this subscale. Categorization of low experience was based on a sum score of less than or equal to 17, and categorization of high experience was based on a sum score of greater than 17. Hence, 43% (n = 83) of respondents were categorized as low in experience and 57% (n = 110) of respondents were categorized as high in experience. Figure 4-5 is a histogram that illustrates this data.

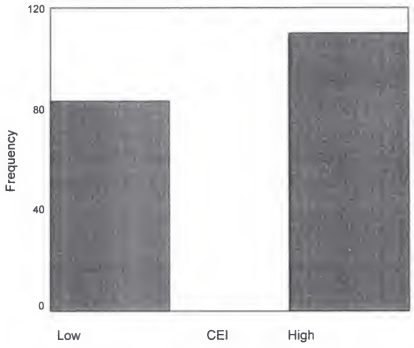

Figure 4-5. Frequency distribution of respondents with low and high CEI.

PEI

Any response of "Yes–Openly" or "Yes–Secretly" was used to categorize the response as "Yes." This procedure resulted in 46.7% (n = 106) of respondents

[1] No respondent indicated "Never" for all items; hence, there was no need for a "No Experience" category.

categorized as having personal experience with infidelity and 53.3% (n = 121) of respondents categorized as not having personal experience with infidelity. Table 4-20 displays descriptive statistics for this subscale. Figure 4-6 illustrates this distribution.

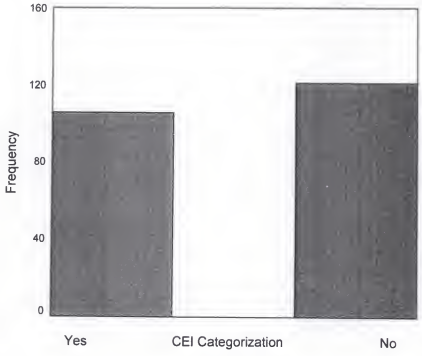

Figure 4-6. Frequency distribution of respondents with and without PEI

FOHI

Any response of "Suspect So" or "Know so" was used to categorize the response as "Yes." Responses of "Don't Know" were not included in the categorization. This procedure resulted in 54.1% (n = 120) of respondents categorized as having family of origin history with infidelity and 45.9% (n = 102) of respondents categorized as not having family of origin history with infidelity. Table 4-20 displays descriptive statistics for this subscale, while Figure 4-7 illustrates the FOHI categorization.

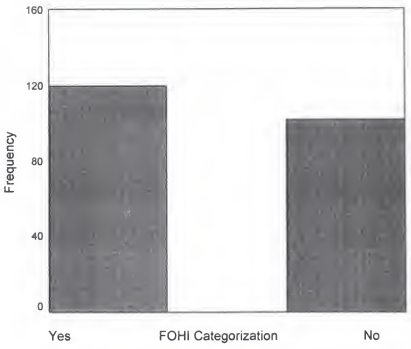

Figure 4-7. Frequency distribution of respondents with and without FOHI

Final Version of Survey

Based on the results of the expert reviews session, the pilot study, and consultation, a final version of the survey was produced. This version can be found in Appendix B.

Reliability

The total number of responses was 227. The reliability statistics for all subscales are displayed in Table 4-21. The four scales prove reliable.

Table 4-21. Item-total statistics and reliability (final)

Test	M	SD	Item N	Sample N	Reliability
IPS	156.27	14.72	62	112	0.81
CEI	17.70	2.76	10	193	0.73
PEI	1.58	2.18	6	220	0.61
FOHI	25.44	13.66	18	202	0.97

IPS

Only the vignette (dilemma) responses were relevant to the present research. The responses to the 62 items yielded a Cronbach's alpha reliability coefficient of 0.81. Hence, the final version of the IPS was considered to be adequately reliable. Item statistics are presented in Table 4-22.

CEI

The responses to the 10 items yielded a Cronbach's reliability coefficient of 0.73. All items displayed moderate discrimination. Since the deletion of no one item would appreciably increase alpha, it was determined that reliability was adequate considering the small number of items in this subsection. Item statistics are displayed in Table 4-23.

PEI

The responses to the six items yielded a Cronbach's alpha of 0.61. Item statistics are displayed in Table 4-24.

FOHI

The responses to the 18 items yielded a Cronbach's alpha of 0.97. All items displayed moderate to high discrimination. The deletion of no item would increase reliability. This subscale was considered to be highly reliable. Item statistics are displayed in Table 4.25.

Table 4-26 summarizes the reliability findings for both the pilot round and the final study round of this initiative. In comparing the reliability coefficients of the scales in the pilot phase with the reliability coefficients in the main study, the table illustrates that reliability increased across the board for IPS (.73 and .81); for CEI (.67 and .73); for PEI (.56 and .61); and for FOHI (.94 and .97).

Table 4-22. Item analysis statistics–IPS (final)

Item	M	SD	Corrected item-total correlation	Alpha if item deleted
1	2.39	1.06	0.35	0.80
2	2.57	0.95	0.15	0.81
3	1.13	0.43	0.28	0.80
4	1.64	0.73	0.39	0.80
5	2.90	0.88	0.27	0.80
6	3.66	0.69	0.39	0.80
7	1.29	0.61	-0.02	0.81
8	2.14	0.88	0.07	0.81
9	3.80	0.42	-0.06	0.81
10	3.78	0.53	0.08	0.81
11	1.83	0.97	0.47	0.80
12	3.73	0.57	0.19	0.81
13	3.01	0.90	0.38	0.80
14	2.28	0.97	0.48	0.80
15	3.10	0.91	0.03	0.81
16	2.41	0.91	0.48	0.80
17	2.24	0.88	0.52	0.80
18	1.85	0.95	0.13	0.81
19	3.70	0.61	0.36	0.80
20	3.55	0.80	0.39	0.80
21	2.21	0.96	0.23	0.80
22	2.27	0.92	0.47	0.80
23	1.62	0.74	0.07	0.81
24	3.28	0.84	0.40	0.80
25	2.23	0.93	-0.08	0.81
26	1.88	0.90	0.37	0.80
27	1.63	0.81	0.48	0.80
28	3.71	0.70	0.24	0.80
29	3.46	0.94	0.42	0.80
30	3.54	0.89	0.37	0.80
31	2.84	1.03	0.29	0.80
32	1.72	0.87	0.51	0.80
33	1.97	0.97	0.42	0.80
34	3.57	0.76	0.35	0.80
35	3.70	0.60	0.46	0.80
36	2.16	1.10	-0.24	0.82
37	3.03	0.90	0.31	0.80
38	3.18	1.08	0.36	0.80
39	1.79	1.11	0.28	0.80
40	1.76	0.92	0.23	0.80
41	2.52	1.15	0.28	0.80
42	3.69	0.57	0.08	0.81
43	2.61	1.20	0.10	0.81
44	2.08	0.92	-0.13	0.81
45	1.85	0.92	0.36	0.80
46	3.00	0.90	0.39	0.80

Table 4-22. Continued

Item	M	SD	Corrected item-total correlation	Alpha if item deleted
47	3.63	0.65	0.39	0.80
48	3.19	0.79	0.18	0.81
49	2.92	0.81	0.25	0.80
50	1.20	0.50	0.15	0.81
51	3.71	0.66	0.19	0.81
52	2.79	0.98	0.07	0.81
53	2.54	0.94	0.00	0.81
54	1.72	0.69	0.23	0.80
55	1.55	0.66	0.24	0.80
56	1.28	0.56	0.13	0.81
57	1.59	0.85	-0.19	0.81
58	1.11	0.41	0.26	0.80
59	3.05	0.97	0.18	0.81
60	2.10	0.88	0.12	0.81
61	2.06	0.96	-0.04	0.81
62	1.54	0.79	-0.14	0.81

Table 4-23. Item analysis statistics–CEI (final)

Item	M	SD	Corrected item-total correlation	Alpha if Item deleted
1	2.02	0.39	0.3025	0.7214
2	2.16	0.48	0.2651	0.7271
3	1.58	0.52	0.3514	0.7152
4	1.45	0.52	0.3752	0.7115
5	2.16	0.56	0.3453	0.717
6	1.96	0.50	0.5125	0.6899
7	1.70	0.52	0.4852	0.6937
8	1.58	0.52	0.4902	0.6931
9	1.58	0.53	0.3391	0.7173
10	1.52	0.56	0.4305	0.7025

Table 4-24. Item analysis statistics–PEI (final)

Item	M	SD	Corrected item-total correlation	Alpha if Item deleted
1	0.09	0.66	0.08	0.67
2	0.04	0.22	0.29	0.60
3	0.05	0.30	0.22	0.61
4	0.52	0.81	0.61	0.42
5	0.53	0.79	0.49	0.49
6	0.36	0.70	0.49	0.49

Table 4-25. Item analysis statistics–FOHI (final)

Item	M	SD	Corrected Item-total correlation	Alpha if Item deleted
1	1.26	0.66	0.46	0.97
2	1.42	0.78	0.62	0.97
3	1.19	0.66	0.57	0.97
4	1.51	0.86	0.63	0.97
5	1.24	0.67	0.49	0.97
6	1.31	0.82	0.67	0.97
7	1.34	0.94	0.89	0.96
8	1.44	0.98	0.82	0.96
9	1.34	0.94	0.89	0.96
10	1.45	1.04	0.87	0.96
11	1.50	1.06	0.85	0.96
12	1.42	1.02	0.88	0.96
13	1.54	1.04	0.82	0.96
14	1.39	0.99	0.88	0.96
15	1.45	1.03	0.87	0.96
16	1.62	1.15	0.83	0.96
17	1.50	1.10	0.84	0.96
18	1.55	1.15	0.86	0.96

Table 4-26. Item-total statistics and reliability (pilot and final)

Test	M	SD	Item N	Sample N	Reliability
IPS					
Pilot	149.31	11.79	61	13	.73
Final	156.27	14.72	62	112	.81
CEI					
Pilot	18.21	2.62	10	34	.67
Final	17.70	2.76	10	193	.73
PEI					
Pilot	2.09	2.09	6	34	.56
Final	1.58	2.18	6	220	.61
FOHI					
Pilot	21.50	8.25	18	30	.94
Final	25.44	13.66	18	202	.97

Results

Main Study

A 2 X 2 X 2 X 2 between-subjects analysis of variance was performed to examine the effects of gender (G), clinical / professional experience with infidelity (CEI), personal experience with infidelity (PEI), and family of origin history with infidelity (FOHI) on infidelity perspectives (IPS). The Type I error rate was controlled at $\alpha = .05$. Of particular interest to this research were the main effects and two-way interactions. Table 4-27 is a summary table displaying the results of the analysis of variance (ANOVA).

Tables 4-28, 4-29, and 4-30 are descriptive summary tables for all conditions including the two levels of gender (male or female) and the combination of the two levels of gender (male and female) as each matches up to CEI, PEI, and FOHI. The data presented includes the number (n) of respondents in the corresponding cell, the mean response and the standard deviation (SD) of the response each person(s) meeting those conditions gave (i.e., Table 4-28: Males with low CEI, with PEI, and with FOHI—n=3; mean response 2.39 and SD .23).

Table 4-27. ANOVA summary table

Source	SS	df	MS	F	p
Gender (G)	0.0008	1	0.0008	0.012	0.91
CEI (C)	0.0766	1	0.0766	1.224	0.27
PEI (P)	0.0360	1	0.0360	0.574	0.45
FOHI (F)	0.0055	1	0.0055	0.089	0.77
G X C	0.0196	1	0.0196	0.313	0.58
G X P	0.2430	1	0.2430	3.887	0.05
G X F	0.0012	1	0.0012	0.020	0.89
C X P	0.2040	1	0.2040	3.257	0.07
C X F	0.0036	1	0.0036	0.058	0.81
P X F	0.0232	1	0.0232	0.371	0.54
Error	10.833	173	0.0626		

Table 4-28. Descriptive statistics for males

CEI	PEI	FOHI	*n*	Mean	SD
Low	Yes	Yes	3	2.39	0.23
		No	2	2.30	0.11
		Total	5	2.35	0.18
	No	Yes	9	2.55	0.30
		No	10	2.66	0.19
		Total	19	2.61	0.25
	Total	Yes	12	2.51	0.28
		No	12	2.60	0.23
		Total	24	2.55	0.25
High	Yes	Yes	6	2.54	0.13
		No	7	2.57	0.18
		Total	13	2.56	0.15
	No	Yes	16	2.56	0.27
		No	11	2.52	0.22
		Total	27	2.54	0.25
	Total	Yes	22	2.55	0.24
		No	18	2.54	0.20
		Total	40	2.55	0.22
Total	Yes	Yes	9	2.49	0.17
		No	9	2.51	0.20
		Total	18	2.50	0.18
	No	Yes	25	2.55	0.28
		No	21	2.59	0.21
		Total	46	2.57	0.25
	Total	Yes	34	2.54	0.25
		No	30	2.57	0.21
		Total	64	2.55	0.23

Table 4-29. Descriptive statistics for females

CEI	PEI	FOHI	*n*	Mean	SD
Low	Yes	Yes	13	2.50	0.22
		No	15	2.52	0.19
		Total	28	2.51	0.20
	No	Yes	14	2.45	0.18
		No	16	2.50	0.15
		Total	30	2.48	0.16
	Total	Yes	27	2.47	0.19
		No	31	2.51	0.17
		Total	58	2.49	0.18
High	Yes	Yes	24	2.57	0.36
		No	14	2.54	0.29
		Total	38	2.56	0.33
	No	Yes	17	2.46	0.28
		No	12	2.49	0.25
		Total	29	2.48	0.26
	Total	Yes	41	2.53	0.33
		No	26	2.52	0.26
		Total	67	2.52	0.30
Total	Yes	Yes	37	2.54	0.32
		No	29	2.53	0.24
		Total	66	2.54	0.28
	No	Yes	31	2.46	0.23
		No	28	2.50	0.19
		Total	59	2.48	0.21
	Total	Yes	68	2.51	0.28
		No	57	2.52	0.21
		Total	125	2.51	0.25

Table 4-30. Descriptive statistics for both genders

CEI	PEI	FOHI	*n*	Mean	SD
Low	Yes	Yes	16	2.48	0.22
		No	17	2.50	0.20
		Total	33	2.49	0.20
	No	Yes	23	2.49	0.23
		No	26	2.56	0.18
		Total	49	2.53	0.21
	Total	Yes	39	2.48	0.22
		No	43	2.54	0.19
		Total	82	2.51	0.20
High	Yes	Yes	30	2.56	0.33
		No	21	2.55	0.25
		Total	51	2.56	0.30
	No	Yes	33	2.51	0.27
		No	23	2.51	0.23
		Total	56	2.51	0.25
	Total	Yes	63	2.53	0.30
		No	44	2.53	0.24
		Total	107	2.53	0.27
Total	Yes	Yes	46	2.53	0.30
		No	38	2.53	0.23
		Total	84	2.53	0.27
	No	Yes	56	2.50	0.26
		No	49	2.54	0.20
		Total	105	2.52	0.23
	Total	Yes	102	2.52	0.27
		No	87	2.53	0.21
		Total	189	2.52	0.25

The analysis revealed a significant two-way interaction of gender and personal experience with infidelity, F (1, 173) = 3.89, $p = .05$. The effect size was small (partial $\eta^2 = .02$). Figure 4-8 is a bar graph indicating that males with personal experience had a lower tendency to disclose infidelity ($M = 2.45$, $SE = .067$) than females with personal experience ($M = 2.25$, $SE = 2.48$). However, males without personal experience had a higher tendency to disclose infidelity ($M = 2.57$, $SE = 2.48$) than females without personal experience ($M = 2.48$, $SE = .03$).

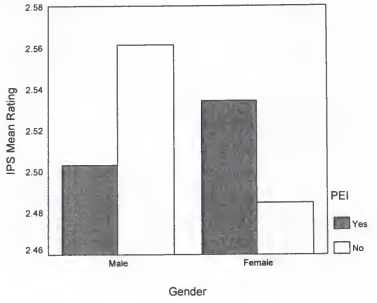

Figure 4-8. Bar graph displaying interaction between IPS and gender

The analysis also revealed a marginally significant two-way interaction of clinical/professional experience and personal experience with infidelity, F (1, 173) = 3.26, $p = .07$. The effect size was small (partial $\eta^2 = .02$). Figure 4-9 is a bar graph indicating that respondents with personal experience that were categorized as high in clinical/professional experience had a greater tendency to disclose infidelity ($M = 2.56$, $SE = .034$) than respondents with personal experience categorized as low in clinical/professional experience ($M = 2.43$, $SE = .06$). However, respondents without

personal experience that were categorized as high in clinical/professional experience had less of a tendency to disclose infidelity ($M = 2.51$, $SE = .04$) than respondents without personal experience categorized as low in clinical / professional experience ($M = 2.54$, $SE = .04$). All other results were not significant.

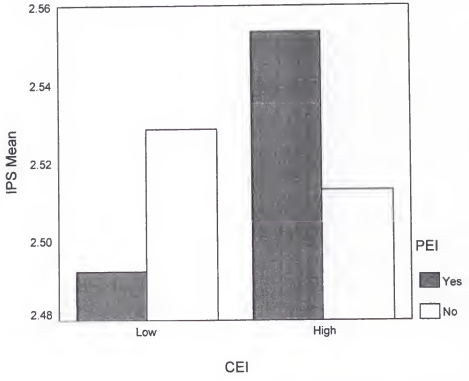

Figure 4-9. Bar graph displaying interaction between IPS and CEI

Qualitative Data

The IPS includes eleven dilemmas that are likely to be encountered during therapy as therapists work with clients dealing with the dynamics of infidelity. In addition to a ready-set of responses provided for each of the dilemma questions, respondents were asked to write-in those actions they take that do not yet appear as part of the prepared responses. A verbatim list (transcription) of the written-in responses for each dilemma situation appears in Appendices G through Q. This data is reported in raw form. Following is a very brief summary of the themes that appear to be emerging from

the write-in answers provided by the respondents under each of the eleven dilemma questions.

Dilemma #1 (Appendix G) is "In couples therapy, when you suspect one of the partners is involved in an affair, you. . ." Sixteen respondents wrote in additional actions taken when faced with this dilemma. Collectively, the responses seem to indicate that if a therapist suspects an affair, he/she would explore the suspicion in a conjoint therapy session with both partners present.

Dilemma #2 (Appendix H) was "When a *partner* suspects the other of an affair and wants your direction on whether or not to spy on his/her partner (i.e., take measures such as taping conversations or hiring a private detective to uncover the suspected affair, you . . ." Thirty-seven therapists responded with additional actions they take. An emerging theme in this dilemma's responses is one of encouraging the suspicious partner to discuss the concerns with the betraying partner first, before taking any actions. Another theme is that of exploring how the suspicious partner would utilize the information obtained from the measures taken, given the ramifications of affirming the existence of an affair. Yet, another theme present is the need to address the issue of the seeming lack of trust in the relationship.

Dilemma #3 (Appendix I) is "When moving from *individual* therapy to *couples* therapy, where the individual has disclosed his/her affair during individual therapy . . . you." Thirty-six therapists responded with additional actions. The emerging themes from the 36 responses are that many therapists would not move from individual to couples therapy to begin with. Determining factors in whether or not an affair must be disclosed under this scenario are: if the affair is in the past; if the affair has ended; and if the purpose of the disclosure is *not* simply so that the betrayer's guilt is diminished.

Additionally, many of the respondents point out that they will not work with a couple together if one of the partners is engaging in an ongoing affair. Moving from individual to couples therapy might be a possibility, without disclosure of an affair if, the affair is ancient, has ended, and/or the betrayed partner is terminally ill.

Dilemma #4 (Appendix J) states "During couples therapy, one partner asks for an individual session, you grant the session and his/her affair is disclosed. You. . ." This dilemma question produced 35 write-in responses. Many therapists would simply not grant an individual session if they were working with the couple already. Therapists disclose up front their "no secrets" policy to clients so that if clients disclose an affair, they (the clients) know before they share the information that the therapist will not keep the information secret from the other spouse. Again, if the affair is ancient, the therapist may be willing to keep the secret. Some therapists will continue couples therapy if the betraying partner agrees to end the extra-relationship affair, and the betraying partner agrees to disclose to his/her partner.

Dilemma #5 (Appendix K) reads "During couples therapy, either through an individual session and/or through another means of direct reporting/admission by the betraying partner, you and the betraying partner agree that an affair is to be disclosed to the betrayed partner. He/she wants to wait. You. . ." This question produced 18 responses. The emerging theme from the write-in responses with this dilemma seems to be that therapists, for the most part, require disclosure rather quickly from the moment they learn an affair is ongoing. It seems that either disclosure is to happen quickly or the couple/people is/are referred to individual therapy with another therapist.

Dilemma #6 (Appendix L) is "You are coaching the betrayed partner on ways to make disclosure to the betraying partner about his/her affair. How much information do

you recommend be shared with his/her partner?" Under this dilemma, 23 responses were written-in. The evolving theme seems to be that the amount of information disclosed depends on what the betrayed partner wants to know. It seems that the responding therapists look to the betrayed partner to lead the way on how much he/she wants to know. Also, therapists caution against sharing information that is shared for voyeuristic/exhibitionistic reasons.

Dilemma #7 (Appendix M) states "In couples therapy, one partner suspects his/her partner is having an affair, believes you know about it (and you do), and asks you directly if his/her partner is having the affair. You. . ." This question inspired 37 write-in responses. The respondents seem to feel strongly that a "no secrets" policy is the ground rule for managing this dilemma. On the other hand, some therapists feel that the information is confidential and it would be unethical to violate the privacy of the person.

Dilemma #8 (Appendix N) inquires "During couples therapy, where either through an individual session and/or through another means of direct reporting/admission, you learn the betraying partner wants to disclose his/her affair to the betrayed partner, you. . ." This dilemma question resulted in 23 write-in responses. The responses were conflicted on whether or not disclosure should take place. The most important factor focused on exploring the reason(s) why the betraying partner wants to disclose. The therapists seem to feel that processing the pros and cons and the dynamics of the relationship would yield the correct approach, especially if health risks are involved in the existence of the dynamics of the affair relationship.

Dilemma #9 (Appendix O) asks "In couples therapy, when you are aware of an affair and, even though no history of violence is present, you believe violence could result from disclosure, you. . ." The summary of the 21 write-in responses suggests that

either therapy is ended, disclosure is discouraged, the violence is dealt with first (assess safety issues/make safety plan) or, because of the very difficult nature of the issue, consultation with a domestic violence expert is sought.

Dilemma #10 (Appendix P) addresses "In couples therapy, the couple asks advice on whether or not to tell their children about the affair. You. . ." The twenty-four write-in responses were widely divided on how to approach this dilemma. The implication of the responses is that action depends on what the children already know, and on why the couple wants to tell. Some therapists encourage not to tell, and instead to respect generational boundaries. Others say to explore the question with the clients.

Dilemma # 11 (Appendix Q) states "In couples therapy, the couple asks for advice on whether or not to tell their extended family about an affair. You. . ." The 13 write-in responses lean towards letting the couple decide or exploring with the couple why they want to disclose. Some therapists feel that the information should be kept private.

Summary of Results

The purpose of this study was to first create a valid and reliable instrument (IPS) to measure infidelity perspective in counselors and therapists, and to then use the IPS to determine the influence of counselors' gender, clinical/professional, personal, and family or origin experience and the interaction between/among those factors on their tendency to promote the disclosure of affairs as part of couples therapy. The study also included the collection of data that provides a glimpse into how clinicians are currently engaging clients when affairs are part of the dynamic of the therapy.

The first research question addressed whether the IPS validly and reliably measures a clinician's tendency to promote the disclosure of affairs as part of couples

therapy. The data first supports that the IPS is indeed a reliable instrument. Its Cronbach's Alpha of .81 implies that it reliably measures the construct of clinicians' tendency to promote the disclosure of infidelity (infidelity perspective) as part of couples therapy. Additionally, the items included to describe CEI, PEI, and FOHI also prove adequately reliable (Cronbach's Alpha of .73, .61, and .97, respectively).

The second research question examined the effect of gender (G) on a clinician's tendency to promote the disclosure of affairs as part of couples therapy. The data demonstrates that the gender of the clinician alone has no significant influence on the clinician's infidelity perspective.

The third research question inquired about the effect of clinical/professional experience with infidelity (CEI) on a clinician's tendency to promote disclosure of affairs as part of couples therapy. The data demonstrates that the variable of CEI alone has no significant effect on a clinician's tendency to promote the disclosure of affairs as part of couples therapy.

The fourth research question examined the effect of personal experience with infidelity (PEI) has on a clinician's tendency to promote the disclosure of affairs as part of couples therapy. The data suggests that PEI alone does not influence a clinician's tendency to promote the disclosure of affairs as part of couples therapy.

The fifth research question explored the effect of family of origin history with infidelity (FOHI) on a clinician's infidelity perspective. The results indicate that FOHI alone does not effect a clinician's tendency to promote the disclosure of affairs as part of couples therapy.

The sixth research question examined the two-way interactions between the combination of the four independent variables of G, CEI, PEI, and FOHI (G x CEI; G x

PEI; G x FOHI; CEI x PEI; CEI x FOHI; and PEI x FOHI) on a clinician's tendency to promote the disclosure of affairs as part of couples therapy. The data demonstrates no significant effect on a clinician's tendency to promote the disclosure of affairs as part of couples therapy when G and CEI interact, when G and FOHI interact, when CEI and FOHI interact, and when PEI and FOHI interact.

However, the data demonstrates that there is a small effect on infidelity perspective (IPS) when G and PEI interact. The data shows that males *with* PEI tend to show a lower tendency to promote disclosure of infidelity during couples therapy than females *with* PEI and, that the males *without* PEI tend to show a higher tendency to promote disclosure of infidelity during couples therapy than females *without* PEI.

Furthermore, the data also revealed a small effect on infidelity perspective (IPS) when clinical/professional experience (CEI) and personal experience (PEI) interacted. Those respondents *with a high level* of CEI and *with* PEI showed a greater tendency to promote the disclosure of infidelity than those respondents *with a low level* of CEI and *with* PEI. However, those respondents *with a high level* of CEI and *without* PEI had a lower tendency to promote the disclosure of infidelity than those clinicians *with a lower level* of CEI and *without* PEI.

Finally, the themes emerging from the "other" response summaries in the qualitative data suggest that as part of couples therapy, clinicians tend to explore their suspicions about affairs in individuals and couples with both partners present, tend to encourage suspicious partners to discuss their suspicions in conjoint sessions, and tend to facilitate discussions pertaining to the intended use of "discovered" information, especially the ramification of affirming the existence of affairs.

Furthermore, therapists tend to intervene by facilitating discussions pertaining to lack of trust in the couple's relationship. Many therapists avoid the issue of disclosure of an affair altogether by not granting individual sessions to members of a couple that the clinician has been treating in conjoint therapy. Or, if the same clinician has been treating the individual, that clinician's policy is to refer the couple to another therapist in lieu of treating that couple himself/herself. Additionally, some clinicians make the determination to promote disclosure based on when the affair took place (in the past or in the recent past, or currently), and if the betrayed is terminally ill. Many clinicians adhere to a strict "No Secrets" policy that is shared at the beginning of couples therapy. Others facilitate discussion of why the betrayer wants to tell. If the reasons are self-serving, the clinician might discourage disclosure. With regard to the type of information to be shared, the clinician allows the betrayed to decide how much information he/she wants to know, why he/she wants to know, and what he/she will do with the information once learned.

Still, some therapists seem to help clients decide how much information to share with children and extended family contingent on what the children and family members already know and on what is gained by the sharing. Others discourage sharing any information about the affair with children and extended family so as to respect generational boundaries and to preserve privacy. The above results are discussed in Chapter 5.

CHAPTER 5
DISCUSSION

Introduction

This study examined the issue of disclosure of affairs in couples therapy vis-à-vis the clinicians' gender and a variety of experiences with infidelity. The sample of participants was randomly derived from the list of clinical members of AAMFT. The resultant sample of 227 clinicians included diverse, experienced members of the clinical community. The initiative was an interdependent process in that the final study was informed first, by expert opinion, and then by the results of a pilot study. Consultation was also relied upon to inform decisions made along the way.

This chapter is organized into 12 sections. Section 1 is the introduction. Section 2 restates the purpose of the study. Section 3 restates the study's guiding questions. Section 4 is a short discussion of the expert opinion results. Section 5 briefly discusses the pilot study. Section 6 addresses the main study and the results under each of the six guiding questions. Section 7 includes the study's implications for theory. Section 8 sets forth the study's implications for practice. Section 9 describes the study's implications for training. Section 10 includes the study's implications for research, including recommendations for a future research agenda on infidelity. Section 11 addresses the limitations of the study. And, finally, section 12 provides conclusions and closure.

Purpose of the Study Restated

The purpose of this investigation was to determine the actions clinicians take when they learn or suspect that a secret affair exists in the lives of the couples they treat

or are about to treat, and how those clinicians' gender, and professional, personal, and family experiences with infidelity, influence the actions they take in their therapy rooms. Three goals were conceptualized.

The first goal was to develop a valid and reliable scale that measures clinicians' level of tendency to promote disclosure when faced with the suspicion or the knowledge of the existence of an affair in the relationship of couples in their care.

The second goal was to identify, and to report, those actions therapists and counselors take when faced with the suspicion or the knowledge of the existence of a secret affair in the relationship of couples those clinicians are treating or considering treating.

The third goal was to determine, analyze, and report how clinicians' gender, clinical/professional experiences with infidelity (CEI), personal experience with infidelity (PEI), and family of origin history with infidelity (FOHI), influence their positions on whether or not an affair must be unearthed or disclosed as part of couples therapy.

In addition to the above goals, and in keeping with Jacobson's (1985) suggestion regarding the need to bridge the gap between research and clinical practice, it was the hope of this researcher/clinician that the following objectives would also be accomplished as a by-product of this research initiative:

- To expose clinicians to real-life scenarios that are part of the treatment of infidelity so that the scenarios would stimulate their thinking as they consider their actions when faced with each dilemma presented in the questionnaire.
- To encourage clinicians to think about whether or not they tend to come to their therapy rooms with unproductive biases and actions based on moralistic attitudes or rigid posturing.

- To disseminate the results into the public domain of the clinical community so that they might be used for treatment-planning, teaching, training, writing, personal development, and further research.

- To augment the academic dialogue that places infidelity on higher ground within the identified clinician training needs—and perhaps be seen as an issue with the same need for focus in couples work as domestic violence and substance abuse.

- To assist clinicians in entering their therapy rooms with less bias and judgmental attitude by beginning the cognitive restructuring process necessary to enable them to conceptualize infidelity (for clinical purposes) as a neutral phenomenon, socially constructed, and viewed in the context of the evolution of love and committed relationships over time.

- To identify a research agenda for future studies on infidelity (perhaps, in part, using the write-in responses provided by the participating clinicians).

Guiding Questions Restated

The following guiding questions framed this study:

- Does the IPS validly and reliably measure therapists' and counselors' tendencies to promote the disclosure of affairs as part of couples therapy?

- In couples therapy, what is the effect of a clinician's gender (G) on his/her tendency to promote the disclosure of affairs?

- In couples therapy, what is the effect of a clinician's clinical/professional experience with infidelity (CEI) on his/her tendency to promote the disclosure of affairs?

- In couples therapy, what is the effect of a clinician's personal experience with infidelity (PEI) on his/her tendency to promote the disclosure of affairs?

- In couples therapy, what is the effect of a clinician's family of origin history with infidelity (FOHI) on his/her tendency to promote the disclosure of affairs?

- In couples therapy, what is/are the effects of the two-way interactions involving the combinations of the levels of gender, CEI, PEI, & FOHI (G x CEI, G x PEI, G x FOHI, and CEI x PEI, CEI x FOHI, and PEI x FOHI) on a clinician's tendency to promote disclosure of affairs?

Expert Opinion

Expert opinion was used as part of instrument development. Although the sample used for this part of the initiative was one of purpose and convenience, it met the criteria

suggested by methodologists (Edmunds, 1999; Weisberg, Krosnick, & Bowen, 1996) for gathering socially oriented qualitative data. One of the characteristics of this particular group of experts was that, similarly to the AAMFT population, the group was composed of 68% masters level and 32% doctoral level clinicians and that, again similarly to the AAMFT population, the group was made up of 68% females and 32% males. Although this was an extremely small sample (N = 11) and therefore not usable to make confident inferences about the population it might represent, it is encouraging to note the hint of representativeness.

The expert opinion phase of this study was most helpful in clarifying, simplifying, and brainstorming the next phase of the study. It was this group that strongly advocated the collapsing the original three definitions of affairs (emotional, sexual, combination emotional/sexual) into one, and it was this group that brainstormed the components of the new, generic definition of an affair that was used first in the pilot and then in the main study.

Upon analyzing the group's collective responses to the questionnaires, it became logical to collapse the three types of affairs (for the purpose of the IPS) into one. This was counter-intuitive to what the literature shows. Glass (2002, 2003b) and Glass and Wright (1988) stress that their research clearly shows the three categories of affairs (emotional, sexual, and combination emotional/sexual), and that conceptualizing affairs from that perspective is essential for clinicians working with affairs. Glass (1999a) emphasizes that clinicians tend to operate with many misconceptions about affairs dynamics and, for that reason, that they might perpetuate many myths when they practice psychotherapy. For example, if a clinician does not differentiate between an emotional

affair and a friendship, he/she might misinform the client(s) about the impact of the affair on his/her/their relationship if it is labeled simply a friendship.

Perhaps further research could be conducted on types of affairs using the IPS as three distinct and separate instruments, each dealing with only one type of affair and collecting the data through three distinct rounds, surveying the same clinicians each time so as to investigate if a difference exists in his/her IPS score when the responses are given separately (and not on the same instrument, at the same time, as was done with this group of experts).

During the expert opinion session, much controversy and debate ensued. Some clinicians felt strongly that the IPS was overly restrictive for the diversified and complicated nature of affairs dynamics. Some clinicians suggested that the dilemmas appearing on the IPS should be transformed into vignettes with corresponding questions. Others suggested that the project was overly ambitious for a dissertation.

It was challenging to call the group back to task inasmuch as they seemed to wish to wander in wherever direction the conversation was going. A great deal of leeway was given to the discussion, while still guiding the flow towards the goals of the meeting—evaluating the instruments under construction. It was especially beneficial to have asked the group to review and complete all documents in advance of the meeting (on their own terms, taking as much time as needed—another piece of information collected to estimate how long the completion of the instruments would take), so that the expert opinion agenda meeting could be flexible and enjoyable while everyone's feedback could still be collected (in writing).

It was obvious by the high level of energy in the room and by the passionate debate that ensued that the topic under consideration was of great interest to the group,

was of immense intellectual stimulation and was quite controversial. Based on feedback following the meeting, the group had much fun. Many expressed a desire to have meetings like this one on a regular basis in the interest of professional growth and networking.

Pilot Study

A pilot study was conducted to further establish the validity and reliability of the instruments (IPS and ICD-Q) under construction. Again, the demography of the pilot sample reflects the same hint of representativeness of the AAMFT population with regard to gender. Similarly to the expert opinion sample, this sample was made up of 64% females and 36% males.

The pilot study established the reliability coefficient of the overall IPS at .73 and the reliability coefficients of the three subscales of the IPS, namely CEI ($r = .67$); PEI ($r = .56$) and FOHI ($r = .94$). Additionally, an item analysis was conducted on the 61 items of the IPS in order to establish that all of the items on the overall scale and on the subscales indeed belong to the scale(s).

Additionally, as with the expert opinion process, the pilot study served to fine-tune the instruments and to assist in predicting how the data collection phase of the main study would occur. Through the pilot study, many changes to the instruments were adopted to maximize the validity of the instruments, and to maximize the number of responses received by making them more user-friendly. This occurred. The response rate of the participants increased from 24% in the pilot to 27% in the main study.

In the ICD-Q, the bolding of some words was adopted to stress some of the instructions. Because some questions were deemed to have been overly challenging to the respondents, as evidenced by their comments and by the number of questions left

blank, choices were created and offered in the areas of treatment model orientation, number of couples treated in career, populations worked with, and number of infidelity cases worked with. The changes created were a vast improvement to the ICD-Q, evidenced by the decrease in blank responses and the absence of negative comments on those items when the instrument was later used in the main study of this initiative.

Changes were also made to the IPS. The directions were changed directly on each question to include not only asking what that clinician *does (or has done)* in the given circumstances when faced with the dilemma, but asking what he/she *would do* if faced with that dilemma (having no personal experience with the dilemma). Additionally, the clinician now had a place to report whether or not he/she in fact had experience with that dilemma. This made the information derived from the IPS responses more accurate and reflective of the truth in therapy rooms.

Main Study

Summary of Results

The purpose of this study was to first create a valid and reliable instrument (IPS) to measure infidelity perspective in counselors and therapists and to then use the IPS to determine the influence of counselors' gender, and clinical/professional, personal, and family of origin experience, and the interaction between/among those factors, on their tendency to promote the disclosure of affairs as part of couples therapy. The study also included the collection of data that provides a glimpse into how clinicians are currently engaging clients when affairs are part of the dynamic of the therapy.

Chapter 4 presented in detail the makeup of the sample of participating clinicians. Overall, the demography of the sample shows that the information obtained in this study emanates from the minds of a formidable group of people—mature, expert, well trained,

widely certified is specialty areas, representative of a wide variety of clinical orientations, and with a diversification in focus and type of work performed.

The sample is predominately white (N= 203 out of 227); two-thirds female (N= 155 out of 227); largely Christian (63%); widely married (60%); strongly liberal and moderate in religious leaning (49% and 26%, respectively); Democrat, liberal, or moderate in Political Leaning (58%, 42%, and 12%, respectively); highly spiritual all of the time or most of the time (86%); largely heterosexual (N=210 out of 227); and diversified with regard to number of lifetime sexual partners.

The response rate in the main study of this initiative (27%) was larger than that of the pilot study (24%). Typically, the rate of response in the pilot phase of a study is either greater than or equal to that of the main study phase. Factors that might have contributed to the improved response rate from pilot to main study here include the following:

- The face validity of both the IPS and the ICD-Q was changed by converting the font from Times Roman to Arial. The change created a crisper looking document, easier to read, with larger and darker print that may have made the instruments more susceptible to being experienced as more user friendly and less cumbersome to navigate. Perhaps this contributed to more participants being willing to respond.

- The instructions on the IPS were changed to include more bolded lines so that additional emphasis on the content was created. The directions were included in bold form on each of the pages of the IPS. The bolding of the instructions emphasized that it was not necessary for the clinician to have had experience with a particular dilemma for him/her to respond. Perhaps this change removed an ambiguity that led some prospective respondents to misunderstand that actual personal clinical experience with a particular IPS dilemma was required to participate. Or maybe the clarification allowed clinicians to give themselves permission to participate even without the actual experience, possibly being able to infer that their responses/opinions would still be useful, and without feeling incompetent.

- The number of questions/dilemmas on each page was shifted so that the instruments looked less crowded and therefore less cumbersome to work through.

- Several items on the ICD-Q were changed dramatically (e.g., work profile, number of couples worked with, clinical/professional experience) so that the respondent now had options (instead of open-ended questions) to choose from. This created a less laborious process for the clinician and possibly a greater willingness to stick with his/her original decision to participate in the study.

The first research question addressed whether the IPS validly and reliably measures a clinician's tendency to promote the disclosure of affairs as part of couples therapy. The data first supports that the IPS is indeed a reliable instrument. Its Cronbach's Alpha of .81 implies that it reliably measures the construct of tendency to promote the disclosure of infidelity (infidelity perspective) as part of couples therapy. Additionally, the items included to describe CEI, PEI, and FOHI also collectively prove reliable (Cronbach's Alpha of .73, .61, and .97, respectively).

The second research question examined the effect of gender (G) on a clinician's tendency to promote the disclosure of affairs as part of couples therapy. The data demonstrates that the gender of the clinician alone has no significant influence on the clinician's infidelity perspective.

The third research question inquired about the effect of clinical/professional experience with infidelity (CEI) on a clinician's tendency to promote disclosure of affairs as part of couples therapy. The data demonstrates that the variable of CEI alone has no significant effect on a clinician's tendency to promote the disclosure of affairs as part of couples therapy.

The fourth research question examined the effect of personal experience with infidelity (PEI) has on a clinician's tendency to promote the disclosure of affairs as part of couples therapy. The data suggests that PEI alone does not influence a clinician's tendency to promote the disclosure of affairs as part of couples therapy.

The fifth research question explored the effect of family of origin history with infidelity (FOHI) on a clinician's infidelity perspective. The results indicate that FOHI alone does not affect a clinician's tendency to promote the disclosure of affairs as part of couples therapy.

The sixth research question examined the two-way interactions between the combination of the four independent variables of G, CEI, PEI, and FOHI (G x CEI; G x PEI; G x FOHI; CEI x PEI; CEI x FOHI; and PEI x FOHI) on a clinician's tendency to promote the disclosure of affairs as part of couples therapy. The data demonstrates no significant effect on a clinician's tendency to promote the disclosure of affairs as part of couples therapy when G and CEI interact, when G and FOHI interact, when CEI and FOHI interact, and when PEI and FOHI interact.

However, the data demonstrates that there is a small effect on infidelity perspective (IPS) when G and PEI interact. The data shows that males *with* PEI tend to show a lower tendency to promote disclosure of infidelity during couples therapy than females *with* PEI and, that males *without* PEI tend to show a higher tendency to promote disclosure of infidelity during couples therapy than females *without* PEI.

Furthermore, the data also revealed a small effect on infidelity perspective (IPS) when clinical/professional experience (CEI) and personal experience (PEI) interacted. Those respondents *with a high level* of CEI and *with* PEI showed a greater tendency to promote the disclosure of infidelity than those respondents *with a low level* of CEI and *with* PEI. However, those respondents *with a high level* of CEI and *without* PEI had a lower tendency to promote the disclosure of infidelity than those clinicians *with a lower level* of CEI and *without* PEI.

Finally, the themes emerging from the "other" response summaries in the qualitative data suggest that as part of couples therapy, clinicians tend to explore their suspicions about affairs in individuals and couples with both partners present, tend to encourage suspicious partners to discuss their suspicions in conjoint sessions, and tend to facilitate discussions pertaining to the intended use of "discovered" information, especially the ramification of affirming the existence of affairs.

Furthermore, therapists tend to intervene by facilitating discussions pertaining to lack of trust in the couple's relationship. Many therapists avoid the issue of disclosure of an affair altogether by not granting individual sessions to members of a couple that a clinician has been treating in conjoint therapy. Or, if the same clinician has been treating the individual, that clinician's policy is to refer the couple to another therapist in lieu of treating that couple himself/herself. Additionally, some clinicians make the determination to promote disclosure based on when the affair took place (in the past or in the recent past, or currently), and if the betrayed is terminally ill. Many clinicians adhere to a strict "No Secrets" policy that is shared at the beginning of couples therapy. Others facilitate discussion of why the betrayer wants to tell. If the reasons are self-serving, the clinician might not promote disclosure.

With regard to the type of information to be shared, the clinician allows the betrayed to decide how much information he/she wants to know, when he/she wants to know, and what will he/she do with the information once learned.

Still, some therapists seem to help clients decide how much information to share with children and extended family contingent on what the children and family members already know and on what is gained by the sharing. Others discourage sharing any

information about the affair(s) with children and extended family so as to respect generational boundaries and to preserve privacy.

Guiding Questions (Discussion)

The first guiding question asked: "Does the IPS validly and reliably measure therapists' and counselors' tendencies to promote the disclosure of affairs as part of couples therapy?"

This question has been previously addressed extensively in Chapters 3 and 4. The findings indicate that, indeed, the IPS validly and reliably measures therapists' and counselors' tendencies to promote the disclosure of affairs as part of couples therapy. This finding is substantiated both through qualitative information and through statistical values in this study. The IPS was created specifically for this study, so no previous research exists from which to draw. This study addresses questions that have not previously been empirically explored in the field.

Many challenges exist in the development of a measuring instrument (Messick, 1995). Per the recommendations of Snyder and Rice (1996), an elaborate series of steps were conceptualized and implemented in order to create maximum confidence in the IPS with regard to its applicability to practice and research.

In order to maximize the creation of an effective instrument, first the instrument's objectives were defined. Specifically, the IPS would measure the tendency of counselors and therapists to facilitate the disclosure of affairs as part of couples therapy.

The vision was for the tendency to be measured/inferred from the synergetic effect of the action(s) the respondents take when faced with a series of "dilemmas" or situations that they are likely to encounter as they conduct therapy with couples. This was accomplished.

The items were generated from a variety of sources. The use of both literature and real-life clinical experience of veteran clinicians, through multiple rounds (8) of scrutiny, contributes to the content validity of the scale (Infidelity Perspective) that measures the construct contained in the IPS questionnaire. The eleven dilemmas, along with the response items (total 62), provided a broad picture of the domain of the construct being measured.

Inasmuch as the majority of the literature on infidelity and infidelity disclosure/discovery is anecdotal, some license was initially taken in compiling items that would eventually make up the final versions of the IPS and the ICD-Q. Both the anecdotal literature (Abrahms-Spring, 1996, 2004; Amodeo, 1994; Brown, E., 1991, 1999; Lusterman, 1998; Pittman, 1989; Schneider, 1988; Silverstein, 1998; Staheli 1995, 1999) and the research literature (Brandt, 1992; Dodini, 2000; Glass, 2003a, 2003b; Glass & Wright, 1988, 1997; Schneider, 1989, Schneider, Corley, & Irons, 2001; Schneider & Schneider, 1990, 1996) establish that the disclosure or discovery of an affair within a couple's dynamic sets in motion a variety of consequences that can be devastating to that couple. So it was important to assure that the IPS reflect accurately real-life circumstances that actually occur during couples therapy—so that we as researchers and practitioners can assess how, in fact, we respond to our clients.

Because every clinical case is somewhat different from every other case, caution was taken to assure that the IPS contained both the universal and the idiosyncratic aspects of the therapy experience of therapists and counselors. As such, specific items were presented and a place for write-in responses provided as well.

The fact that many respondents contributed additional actions they take indicates that the respondents were deliberate in responding to the survey. Those responses are

additional options that may be added to the response set under each of the 11 dilemmas. Perhaps a Modified Delphi Study (Dalkey & Helmer, 1963; & Linstone & Turoff 1975) can be conducted to achieve consensus on what might constitute a more complete response set under each of the eleven dilemmas. Delphi Studies have been previously used in the study of infidelity (Brandt, 1992).

Responses obtained from expert opinion solicitation verified that each of the eleven dilemmas is indeed encountered during the course of couples therapy. The question was specifically asked on the worksheet provided to the consensus group (Appendix F). Interestingly, during the process of evaluating the instrument, many clinicians commented that reading some of the dilemmas raised their awareness of the fact that they encounter those situations in the course of their work—in other words, the IPS directed their focus in a proactive way on the work they are already doing and had not yet reflected upon.

In keeping with Snyder and Rice's suggestions (1996), in order to establish and accrue validity data, the items on the IPS were pretested. Pretesting occurred first by administering them to a group of experts (the consensus group), and then through piloting. In examining the feedback and the data for both the content and the format of the IPS and the ICD-Q, changes were made that strengthened the viability of the instruments. The face validity of the IPS and the ICD-Q was also improved with each of the rounds of the process.

So that measuring instruments are viable, they must be reliable. Reliability is a necessary condition for validity (Mark, 1996). Strong reliability assures that measurement error is minimized. Although error cannot be avoided altogether in research, employing random sampling techniques can minimize it. This was done in this

atudy. The participants in both the pilot and the main studies were randomly selected from a sampling frame. The questionnaires were sent to N = 250 and N = 1000 (pilot and study, respectively). The rates of response (24% and 27%, respectively) are aligned with the expected response rate in survey research conducted through the mail (Weisberg, Krosnick, & Bowen, 1996).

The reliability of the IPS suggests that the IPS performs well in measuring the tendency of counselors and therapists to facilitate the disclosure of affairs as part of couples therapy. The overall IPS Cronbach's reliability coefficients of .73 in the pilot study and .81 in the main study shows the instrument to be adequately reliable, and establishes its internal consistency (Cronbach, 1949).

According to Litwin (1995), levels of reliability of .70 or greater are generally accepted as representing good reliability. Given this standard, in addition to the overall IPS reliability, the three other scales on the ICD-Q (those for the independent variables of CEI, PEI, and FOHI) also measured reliable (r = .73; r = .61; and r = .97, respectively). The low score of .61 on the PEI scale might be explained by the fact that, generally, a question that asks people about their current extra-relationship affairs/involvement might be an overly personal and might be experienced as overly personal and intrusive, and unsafe to warrant an honest response.

In the pilot study, the responses to the items on the PEI scale indicated that the clinicians, or his/her partner, tended *not to be* presently involved in an affair. However, when asked if in the past this was so, approximately 60% of those responding reported having been involved in an affair. The social desirability needs of the respondents might have influenced their responses to the first three items on the scale.

This attitude in people is supported by the literature. Secrecy is the cornerstone of infidelity (Pittman, 1989a, 1991, 1993). It makes sense that clinicians, like nonclinicians, would be unwilling to admit that they are involved in a secret affair. Perhaps if the question had been less direct and/or if the number of items increased, the level of the PEI reliability scale might have been higher.

Theoretically, at any given time, women are having affairs at the rate of 26% and men are having affairs at the rate of 50% (Kinsey et al., 1948, 1953). Clinicians are part of the human population and, as such, the infidelity rates should be the same among clinicians as among nonclinicians. Using this rationale, the clinicians' current involvement in affairs should approximate that of the general population at any given time.

This was not the case in this inquiry. More items on this scale and/or items that describe specific, less threatening individual behaviors that, when compiled, would indicate an ongoing affair (e.g., secret phone calls, sexual chemistry, romantic kissing, etc.) might have increased the respondents' willingness to be more truthful or open and therefore might have increased the reliability coefficient of the PEI scale. This point can be further investigated in future research.

The second guiding question asked "In couples therapy, what is the effect of a clinician's gender (G) on his/her tendency to promote the disclosure of affairs?" The data shows that the gender of the clinician alone has no significant influence on the clinician's infidelity perspective ($p = .91$).

This result was somewhat surprising inasmuch as the literature on infidelity is prolific on the existence of gender differences as they pertain to infidelity attitudes (Buss, 1989; Wiederman & Allgeier, 1992); marital satisfaction (Glass & Wright, 1985); rates

of forgiveness (Shackelford, Buss, & Bennett, 2002); and evolutionary perspective (Fisher, 1992; Wright, 1994).

Newberry, Alexander, and Turner (1991) help place this finding in the context of the literature on gender, sex roles, and behaviors. They point out that the literature offers conflicting and confusing results on the way gender, sex roles, and behaviors integrate in the therapeutic process.

It was expected that, with regard to tendency to facilitate disclosure during couples therapy, a difference would exist between male and female clinicians. For example, Shackelford, Buss, and Bennett (2002), through a study of forced-choice dilemmas, asked participants (N = 256) how difficult it would be to forgive a partner following infidelity. Men were more unlikely to forgive a sexual infidelity than women, and men were more likely to terminate a current relationship following a partner's sexual infidelity than were women. It seemed plausible that, given the difference in the male and female responses in their study, that in this study there would be a difference in male and female IPS.

A possible explanation for there being no gender difference in IPS is that defining gender as was done in this study as a two dimensional variable (male and female, without regard to any other dimension) does not reflect the possibility that gender is best reflected on a continuum that spans between extreme levels of femininity and masculinity, as proposed by Worden and Worden (1998) and Deux & Major (1987). Similarly, Newberry, Alexander, and Turner (1991) found that family members (clients) respond differently to male and female therapists based on their roles in therapy. This supports the idea that gender is more a function of behavior than the type of genitals possessed by the therapist.

Had this variable been designed as a variable based on the summary of a constellation of behaviors to determine the maleness or femaleness (based on traditional roles) of the participants, the data might have indicated that gender (ness) does indeed affect infidelity perspective during couples therapy. This question can be examined in further research.

The third guiding question asked "In couples therapy, what is the effect of a clinician's clinical/professional experience with infidelity (CEI) on his/her tendency to promote the disclosure of affairs?" The data indicated that when CEI is analyzed as a main effect, it is not significant ($p = .27$).

This finding converges with the literature. Several theorists (Brown, 1991; Glass, 1999a, 2003b) propose that, despite the many number of years in clinical practice, therapists still are vulnerable to myths, distortions, and personal preferences and morals when working with affairs.

According to E. Brown (1991), when working with infidelity, many therapists experience their roles as ambiguous, difficult, and painful. Glass (1999a, 2003b) points out that, notwithstanding high levels of clinical experience, therapists, as with the members of the couple entering therapy, bring mythic assumptions to the work with/as couples. In her research with therapists (Glass, 1999a), she discovered that 53% of female therapists and 39% of male therapists still disagree with the proven knowledge that infidelity occurs in happy marriages/relationships. Glass (1985) found that 56% of men and 34% of women who engaged in extramarital intercourse reported that their marriages were happy. Myers and Leggitt (1972) not only propose that infidelity happens in happy marriages but also suggest that, at times, it enhances the marital relationship.

The fact that CEI as a main effect has proven to have no significant impact on IPS has implications for the training of clinicians. It is reasonable to hypothesize that level of clinical experience with infidelity alone does not prepare clinicians well to work with infidelity without specific specialized training that includes information pertaining to the debate regarding the disclosure of affairs and its impact on couples work. A curriculum similar to the one proposed by Ford and Hendrick (2003), and that includes the works of theorists (Brown, E., 1991, 1999; Glass, 2003a, 2003b; Lusterman, 1998; Moultrup, 1990; Pittman, 1989; Vaughan, 1998) and researchers (Glass, 2002, 2003b; Glass & Wright, 1977, 1992; Schneider, 1988; Schneider & Corley, 2002; Schneider & Schneider, 1990; Wiederman, 1999a, 1999b, 1999c) can better prepare clinicians to work using a protocol for promoting the disclosure of infidelity as part of therapy. This would be in addition to the appropriate foundational training suggested by Figley and Nelson (1989, 1990), Keller, Huber, and Hardy (1988), Nelson and Figley (1990), and Nelson, Heilbrun, and Figley (1993).

The fourth and fifth guiding questions are treated together in this discussion. The fourth guiding question asked "In couples therapy, what is the effect of a clinician's personal experience with infidelity (PEI) on his/her tendency to promote the disclosure of affairs?" The data shows that PEI alone does not influence IPS ($p = .45$).

The fifth guiding question asked "In couples therapy, what is the effect of a clinician's family of origin history with infidelity (FOHI) on his/her tendency to promote the disclosure of affairs?" The data shows that FOHI alone does not influence IPS ($p = .77$).

The findings were surprising. E. Brown (1991) points out that, despite the fact that clinicians are able to carry to the therapy table a system of thinking about both

interpersonal and intrapersonal dynamics, skills, and values that are codified by various professional associations, clinicians cannot avoid having their own personal values and experiences color their approach to therapy. Therefore, it was anticipated that PEI and FOHI would influence clinicians' infidelity perspectives because personal and family experiences are a central part of any person's context and a central part of what informs his/her worldview.

The literature is prolific in addressing the legacies that family systems create for their members (Boszormenyi-Nagy, 1965; Bowen, 1978; Carter & McGoldrick, 1999; Haley, 1976; McGoldrick, Gerson, & Shellenberger, 1999). Eaker-Weil and Winter (1994) proposed that adultery is a forgivable sin and is a behavior that is perpetuated in families from one generation to the next.

The Family Systems perspective strongly underscores the impact that the dynamic of a family system has on its members. By all accounts, the personal and family experiences lived by the clinicians should result in major impact on decision-making, and perhaps they *do* in their personal lives, *but not* in their therapy rooms—at least not according to the findings in this study. It is conceivable that the academic training clinicians receive assists them in separating their thoughts from their feelings and actions so that adequate levels of differentiation (Bowen, 1978) exist in the clinicians, enabling them to maintain the professional distance necessary to derail their own projections on their clients. Maroda (1994) and Silverstein (1998) underscore this concept.

Cain (2000) and Rosenberg and Hayes (2002) examined the phenomenon of countertransference in wounded healers (psychotherapists). In a qualitative study, Cain (2000) determined that wounded healers (psychotherapists with personal histories of psychiatric hospitalization) do in fact experience a range of countertransference issues,

including varying degrees of identification with clients. Because of the existence of their own experience as clients, clinicians' philosophies and interventions of treatment were affected.

This was not the case with this study. The findings in this study are better supported by the findings of Ford and Hendrick (2003), where they found that, although therapists may differ selectively in their sexual values depending on their gender, religious involvement, and political affiliation, their training in sexual issues is helpful in clinical work. And even though therapists encounter sexual values dilemmas, they are able to recognize the dilemmas and handle them ethically.

Silverstein (1998) delineates countertransference dilemmas encountered by clinicians who treat infidelity in marital therapy. She supports the ideas previously presented by others that, during therapy, the clinician's reactions to the clients that are conscious are less likely to interfere in the therapy process—but when nonconscious, the work may be negatively affected.

Rosenberg and Hayes (2002) reviewed the empirical literature on countertransference. The three definitions for countertransference they outline shine light on what might be a dynamic in clinicians and why it might be that the clinicians' PEI and FOHI in this study did not significantly affect their IPS.

Rosenberg and Hayes (2002) attribute the classical definition of transference (the analyst's unconscious, neurotic reactions to the clients' transference) to Freud (1910/1959), Reich (1951), and Stern (1924), and surmise that this type of counter-transference is counter therapeutic and must be avoided at all costs.

The fact that the participants in this study are veteran therapists, with knowledge regarding the impact of their own issues and experiences on the way they conduct

therapy, may make them more vigilant to remaining appropriate and adequately detached in their roles as therapists.

Rosenberg and Hayes (2002) further identify the totalistic definition for countertransference (the entirety of counselors' reactions, conscious, and unconscious, neurotic and reality-based, whether in response to clients' transference or to other phenomena; and feelings the counselor experiences towards the client) and attribute it to Fromm-Reichmann (1950), Heimann (1950), Kiesler (1982), and Little (1951). When the totalistic type of countertransference is present, the outcomes are not necessarily detrimental. They point out that, when it is reflected upon, the countertransference is a possible source of insight into the clients and the counseling relationship.

Finally, Rosenberg and Hayes (2002) offer a definition for the moderate form of countertransference (the therapist's reactions to the clients contain a mixture of reality-based and reactions that originate from areas of unresolved conflict in the therapist) and attribute it to the work of Berman (1949), Blanck & Blanck (1979), Gelso & Carter (1985), Gelso & Hayes (1998), Ginter & Bonney (1993), and Langs (1974). This type of countertransference must be managed well in the therapeutic process. When it is not managed well, it will have a negative influence on the process and outcome. However, when the energy is managed well, the therapist's awareness of his/her reactions can provide critical insight into important client and relationship dynamics.

Perhaps the lack of PEI and FOHI influence on IPS is attributable to the fact that the clinicians in this sample possess adequate awareness about their own tendencies and biases (contertransference) related to infidelity and, as such, were able to create proper boundaries (Katherine, 1991) between themselves and their clients. Because of this, they

are able to analyze and successfully process, as suggested by Ford and Hendrick (2003), their own biases regarding infidelity so that the impact/effect is undetectable.

The sixth and last guiding question asked "In couples therapy, what is/are the effect(s) of the two-way interactions involving the combinations of the levels of gender, CEI, PEI, & FOHI (G x CEI, G x PEI, G x FOHI, CEI x PEI, CEI x FOHI, PEI x FOHI), on a clinician's tendency to promote disclosure of affairs?"

The data demonstrates no significant effect on clinicians' tendencies to promote the disclosure of affairs as part of couples therapy when G and CEI interact (p= .58); when G and FOHI interact (p=.89); when CEI and FOHI interact (p= .81); and when PEI and FOHI interact (p= .54).

However, the data demonstrates that there is a small effect on infidelity perspective (IPS) when G and PEI interact—$F(1,173) = 3.89$, $p = .05$. The data shows that males *with* PEI tend to show a lower tendency to promote disclosure of infidelity during couples therapy than females *with* PEI and, that males *without* PEI tend to show a higher tendency to promote disclosure of infidelity during couples therapy than females *without* PEI.

In the study, PEI was the sum of six statements related specifically to whether or not the respondent and/or his/her partner were, currently or in the past, either openly or secretly, either a betrayer, a betrayed, or the other (wo)man. Gender (G) and PEI alone do not affect infidelity perspective in clinicians.

The literature has shown that males tend to engage in extra-relationships more frequently than do females. Perhaps, as a result, male clinicians who have engaged in affairs know first hand the repercussions of being discovered and, as such, may shy away from encouraging the disclosure of the affair in the couple they are working with. Or, if

the betrayer in the couple is male, perhaps the clinician is identifying with him and gives him preferential treatment by trying to protect him from being on the receiving end of the messy and laborious aftermath of disclosure.

Kelly and McKillop (1996) reviewed the theories and empirical findings concerning what the aftermath of revealing personal secrets is. They contend that there are many times when a secret is better kept hidden. They suggest that the real or perceived feedback and backlash the person believes he/she will receive from the person hearing the information is critical to determining if the secret keeper will benefit from revealing the information. Perhaps clinicians consider this and work at facilitating the status quo of the couple's homeostasis (Jackson, 1969). Moultrup (1990) cautions clinicians not to be zealous at disrupting the delicate balance between the members of a couple.

Secrets tend to be about negative information and, as such, the person may fear that, if discovered, he/she will experience loss of esteem or status. Schneider, Irons, and Corley (1999) studied sexually exploitive, mostly male (89%) helping professionals and issues related to disclosure of their misconduct to their families (spouse). What the participants feared most was being left (abandoned). Despite this fear, of the 60% of partners who did threaten to leave, only 23% actually did leave by the time of the follow-up study. In the follow-up study, fewer betraying partners (68%) than betrayed partners (81%) recommended disclosure.

The above study converges with the findings in the study at hand. The male clinicians with personal experience promote disclosure at a lower rate than the females. However, not knowing if the clinician is the betrayer, the betrayed, or the other man/woman, limits what can be extrapolated from the findings.

Interestingly, when comparing male and female clinicians without PEI, males without PEI tend to more frequently promote disclosure than do females without PEI. Perhaps, although not explored in this study, the fact that the male does not have PEI may reflect a lower sexual desire, and as such, he may blame the partner with lower sexual desire (especially if sex appears to be the central issue and/or he is operating under the impression that affairs are primarily about sex) for the advent of the affair because the betrayer is justified in going outside the marriage for physical and/or emotional companionship. Men may also be able to compartmentalize life with more ease than women and feel less guilt (Abraham, Cramer, Fernandez, & Mahler, 2002; Browning, Kessler, & Hatfield, 1999; Cramer, Abraham, Johnson, & Manning-Ryan, 2002; Gentry, 1998).

That women would be less likely to promote disclosure may be attributed to the existence of traditional female attitude of looking the other way or of accepting that which male partners decide and/or do. Also, not having had exposure to the effects of infidelity in their own relationship, female clinicians may promote the tendency to remain in denial regarding the possibility that an affair exists in the relationship of couples treated. She may collude with the secret because she may not want to believe that affairs happen at the high rates that they actually do in the clinical population. Due to their own unresolved issues, both male and female clinicians may simply not want to do the work with the couple (Silverstein, 1998).

At this time, the generalizability of these results is limited in part because the analysis of the data collected did not include a comparison of the tendency to promote disclosure of affairs in males *with* and males *without* PEI and then again a comparison of females *with* PEI and females *without* PEI. This information would have clarified if it is

the males that remain constant or if it is the females that remain constant when each either has PEI or does not have it. Therefore, a t-test (two groups) and/or a within-subject analysis would have yielded important information in answering this part of the question under study.

The data also revealed a small effect on infidelity perspective (IPS) when clinical/professional experience (CEI) and personal experience (PEI) interacted—$F(1,173) = 3.26$, $p = .07$. Those respondents *with a high level* of CEI and *with* PEI showed a greater tendency to promote the disclosure of infidelity than those respondents *with a low level* of CEI and *with* PEI. However, those respondents *with a high level* of CEI and *without* PEI had a lower tendency to promote the disclosure of infidelity than those clinicians *with a lower level* of CEI and *without* PEI.

These results indicate that the higher the CEI in clinicians with PEI, the higher the tendency to promote disclosure. When the clinician has no PEI, the higher the CEI, the less the tendency to promote disclosure.

Perhaps if a clinician has no PEI but high CEI, he/she might be dissuaded by the pain and struggle clients experience as they deal with the affair in the open. If their CEI does not include focused training on infidelity, or perhaps lacks even basic knowledge derived from books or journal articles (Glass, 2002) despite the amount of work they perform with infidelity, they might be continuing to operate with the types of myths suggested by Glass (1999a) or the types of biases suggested by E. Brown (1991, 1999) and Silverstein (1998). Due to inadequate training and feelings of incompetence, they may simply feel immobilized by the overwhelming energy and pain present in the work.

When the clinician has low CEI and no PEI, according to these findings, they are more likely to promote the disclosure of affairs during therapy. They might be entering

the therapy room with rigid, judgmental attitudes about honesty-at-any-cost, unrelated to client factors, values, or beliefs, or perhaps they are righteously making decisions for their clients.

Lack of PEI and low CEI leaves the clinician in unfamiliar territory. He or she may be unable to lead that couple, as Glass (2002, 2003b) suggests, towards fostering caring, fostering good will, creating safety, managing the affect and posttraumatic symptoms, and in helping the couple to first create and then to tell the story of the affair. The clinician might make fatal errors, such as failing to maintain effective balance, giving up on the couple too soon, and terminating badly so that the couple's ambivalence is not properly resolved and the affair triangle continues as a source of pain and mistrust.

Again, a t-test and/or a within-subject analysis of these variables was not performed and the data was not examined from the perspective of clinicians *with high* CEI and *with* PEI being compared with those *without* PEI, and clinicians *with low* CEI being compared with clinicians *with* PEI and *without* PEI. This finding would have clarified if the effect obtained in the study were due more to CEI or to PEI in the clinicians. For future research, a t-test and/or a within-subject analysis is recommended.

In addition to the previous possible explanations for the interactions discovered in this study is the fact that an important piece of information is missing from the puzzle. Namely, it is not yet known what about the clinician's (whether male or female) personal or clinical experiences, or about what happened during his/her work or his/her own relationship interactions, impacted his/her inclination to promote disclosure and created the interactions found here. Although additional data were collected on each clinician's personal fundamental beliefs about affairs, specific professional practices regarding treatment (Appendix B) and actual occurrences following disclosure of affairs during

his/her work (Appendix B) were not analyzed. Therefore, a more complete picture of both the clinician's personal (PEI) and clinical/professional(CEI) experiences could be obtained from the data already collected. Further research can advance the quest for more clarity and perhaps offer more confident answers to the questions.

Implications for Theory

The process of and the discoveries made during the literature review for this study illustrated that the theoretical framework on which couples therapy for infidelity is built is fragmented. Early on, many have pointed out the lack of consistent and unified language and nomenclature with which to frame the concept of infidelity (Knapp, 1975, 1976; Ramey, 1977a; Thompson, 1982, 1983; Whitehurst, 1969. The problem persists in the present (Glass, 2003b; Jenks, 1998).

The myriad of typologies for conceptualizing affairs indicates the lack of consensus among clinicians as to what is the best way to think about affairs (Brown, 1991; Brown, R., 1999; Collins, 1999; Maheu, 2003; Hendrix, 1988; Kaslow, 1993; Lusterman, 1998; Pittman, 1987; Staheli, 1995). Additionally, there are those who suggest addressing some aspect of infidelity as a sexual addiction, therefore using the addiction model of treatment (Carnes, 1991, 1992; Schneider, Corley, & Irons, 1998). Still some theorists are researchers and base their typology on observations they have made in both their practices and their studies (Glass & Wright, 1985, 1988, 1992).

Although there is great value to embracing the concept of variety, clients would benefit greatly from a more unified approach by the clinical profession vis-à-vis ways to conceptualize affairs. A theory that embraces the best of what already exists, emanating from the observations of clinicians and scholars, is needed to integrate the existing knowledge.

As a clinical community, we do have some consensus on certain aspects of the field of infidelity. For example, Whisman, Dixon, and Johnson (1997) gathered opinions from marital therapists and concluded that affairs are the third most difficult problem to treat and the second most damaging problem that couples encounter.

We also know from Brandt's (1992) work the challenges encountered by therapists as they attempt to treat infidelity. We have been able to identify the stages of the aftermath of disclosure (Olson, Russell, Higgins-Kessler, & Miller, 2002; Rhodes, 1984). We know that when disclosure occurs, it must be done as a process and that, invariably, threats to leave accompany disclosure. We also know that those threats tend not to be carried out by the betrayed (Schneider, Corley, & Irons, 1998; Schneider, Irons, & Corley, 1999).

Several clinicians have identified models for treating infidelity. For example, some suggest using the trauma model (Glass, 2003b; Glass & Wright, 1992, 1997; Lusterman, 1998), while others suggest the addiction model (Carnes, 1991, 1992; Schneider & Irons, 2001). Others offer steps for treatment (Lusterman, 1998; Pittman, 1987). And then there are some (Brown, 1991) who associate type of affair with its expected outcome following treatment.

A unified theoretical approach could give access to all the information to those who study and practice therapy for infidelity, including clients. An integrated theoretical framework with unique and specific nomenclature that includes all that we know so far, and with specific guidelines for assessment and intervention practices, can empower clinicians to work more effectively with their couples. The anecdotal literature is extremely useful in assisting clinicians to conceptualize affairs, and even in creating a stage for preparing interventions. As a field, the research literature and the anecdotal

literature has not yet been integrated. This study has begun the process and lends itself to further steps towards this endeavor.

The results of this study showed no main effect for Gender, Clinical Experience, Personal Experience, and Family of Origin History with Infidelity, and some interaction between Gender and Personal Experience and some interaction between Clinical Experience and Personal Experience. It seems that Personal Experience tends to interact in some way to affect clinicians' infidelity perspectives. And so does Clinical Experience. Reworking the research design to isolate these independent variables further and hypothesizing about the new results can be useful to creating new theories about gender differences, the role of clinical experiences and the role of personal experiences in the therapy process. The additional information would also augment the theoretical framework of the literature on transference and countertransference, and the theoretical framework of the concept of family legacies within the framework of family social science.

Implications for Practice

Great care is given to training competent, diverse, motivated clinicians. The field has evolved with the passage of time. The various professional organizations have cooperated with the various parts of the world to operationalize and professionalize the practice of therapy, taking into account the needs of the clients, the needs of the industry, and the laws of the land. Accreditation of programs, careful supervision of students and interns in training, and life-long learning have become commonplace in the clinical community. Yet, specialized training in the area of infidelity work is lagging behind other types of training that deal with devastating issues in society. This study has many implications for practice. Some are presented here.

The information derived from this study, especially the write-in responses, is useful in practice because it describes in an imitable way actual actions taken by clinicians as they conduct infidelity therapy. For example, if a secret affair is suspected or known by either the clinician and/or a client, how the decision is made and how to go further is described. Typically, the clinicians' actions reflect that many of the decisions made in the course of this type of work are made on a case-by-case basis. This implies that if procedural standards were created, they may be inadequate to fit every situation. This could produce much stress for a therapist who practices strictly according to the professional and ethical guidelines provided by our governing bodies. On the other hand, learning that decisions made on a case by case is a normal phenomenon in the work of infidelity can validate the clinician who is willing to practice in the gray area of certainty.

One of the most prevalent implications of this study for practice is that such a large part of this work depends on the clinical judgment of the clinician, and that working with infidelity requires the clinician to be well trained and have a robust will, and a strong ability to witness and participate in work that is naturally emotionally charged and intense. The clinician must be comfortable in crisis intervention and support, and must be willing to remain available to the member of the couple for in-between sessions contact.

The IPS can provide the clinician with scenarios/dilemmas that can assist him/her to focus on the elements of dynamic of affairs. Specifically, knowing, for example, that seeing and managing potentially violent and abusive behavior can be part of the work, knowing that clients exhibit strong symptoms such as obsessive, suicidal, suspicious, ambivalent thought, managing the influx of information filled with lies, deceit, lack of commitment (temporary or permanent), lack of trust, addictive behavior, rage,

descriptions of sexual issues and sexual behaviors (some of which are unconventional) and of course divorce, can help a clinician prepare as he/she approaches the work.

Knowing the above information can help him/her in deciding the more fundamental question of whether or not to work with the couple or refer them on to someone who feels more confident in doing the work.

Specifically on the issue of disclosure, the study points out that in the clinical community there are those like Pittman (1987) who promote disclosure—or couples therapy will not take place. There are those who believe that the decision should be made on a case-by-case basis, or as E. Brown (1991) suggests, wait for a while if necessary but disclosure is necessary. Still others, similarly to Glass (2002), help the betrayer prepare the disclosure but suspend conjoint therapy in the interim. And finally, there are some clinicians who, like Humphrey (1981), endorse keeping the secret (honoring confidentiality) and simply work on improving communication within the couple.

Implications for Training

The field is wide open with regard to training therapists to conduct work in infidelity treatment of couples. Many shy away from it (Silverstein, 1998), while others do it but feel confused, overwhelmed, and unprepared (Brown, 1991, Glass, 2002). The prevalence of infidelity in couples work (Glass & Wright, 1977, 1988) makes training an essential part of preparing effective therapists.

The data showed no main effect for the influence of gender, clinical experience, personal experience, and family of origin with infidelity on clinicians' tendencies to promote disclosure during couples therapy. Yet, the existing literature on gender

differences, personal and professional biases implies that effect exists. The IPS and the ICD-Q lend themselves as training tools. Following are some ideas for their use:

- Administer both the IPS and the ICD-Q to graduate students in Psychology, Marriage and Family, Mental Health, Marital Therapy and Sex Therapy classes and have them examine their own positions on the eleven dilemmas. Utilizing the methodology used in this study, a profile for that class can be created and used as a point of reference for discussions and other learning.

- Create a structured activity (using the IPS) to be used in marriage classes, workshops, and conferences that would lend itself to the sharing of opinions, attitudes regarding infidelity, including ethical considerations to remember. Possible questions to be asked include: (a) Does the dilemma happen? (b) What else happens when the situation described in the dilemma takes place in the lives of the clients and how should it be handled? (c) What are the ethical considerations inherent in this dilemma and what safety measures must be put in place so as not to contribute to the situation escalating to a dangerous level? (d) How is confidentiality handled under each of the dilemma situation? And (e), what are your responsibilities to each client, to society, to the other man/woman, etc.

- Compile and publish for clinicians a list of materials that includes academic literature, training opportunities (including past recorded seminars) and self-help books to be used as bibliotherapy that addresses the various layers of infidelity treatment for both the clinician (conducting the treatment) and the clients (consumers of treatment).

- Create structured networking opportunities to share clinical experiences, as suggested by the experts at the consensus-building meeting of this initiative. This promotes the identification of referral sources and the opportunity to share innovations in practice, mentoring, and to promote other types of professional growth.

- Develop a semester-long curriculum for advanced students that promotes the acquisition of knowledge, awareness, and skills necessary to creating competent therapists ready to work with couples. If program requirements can't afford the time and cost necessary for a whole class, then produce a comprehensive module on infidelity to be inserted in marriage or sexuality classes.

- Form a self-awareness group (a lab-like activity) for clinicians-in-training that would be part of a graduate class addressing relationships. Part of the agenda of that group would be to challenge the beliefs, values, etc. of the people—what they think, feel, believe—using each of the dilemmas as a springboard for the discussion. The awareness created could be integrated into the didactic portion of the class in a deeper fashion.

- Advocate for mandatory continuing education credits requirements as part of licensure requirements similar to those for HIV, Domestic Violence, and Medical Errors. Clinical supervision should be part of the program.

Implications for Research and Ideas for Future Research

The research implications from this study are many. First and foremost, modification of the IPS and the ICD-Q can greatly enhance their usefulness. More complete forms can be created using the write-in responses provide by the participants. Also, validation of the IPS can be enhanced if its scale is correlated with an already established instrument that measures a construct such as assertiveness, leadership, authoritarianism, locus of control, etc.

The lack of significance for main effect of the G, CEI, PEI, and FOHI on clinicians' tendencies to promote the disclosure of affairs as part of couples therapy indicates that the design of this study needs to be reworked to focus on better ways to isolate and measure these independent variables.

For the G variable, introducing a way to determine the "maleness" or "femaleness" of the clinician and then seeing its effect on his/her tendency to promote disclosure could prove significant. Evaluating the gender of the clinician in this "new" way could help place him/her on a continuum of cluster behaviors that tend to be male or female, as suggested by Post-Modernists (Worden & Worden, 1998).

The way the CEI variable was measured needs to be reworked and more items added to the scale. Other information collected on the ICD-Q and the IPS parts B and C (Appendix B) may be used to strengthen the CEI measurement. Specifically, information on the clinician's beliefs about affairs, on the number of cases involving infidelity worked on by the clinician, and on the aftermath of disclosure actually professionally experienced by the clinician might permit a refinement of the clinician's CEI.

Additionally, a new question could be asked that would gather information pertaining to the amount and type of training undertaken by that clinician. Glass (2002) reports that of the 350 clinicians she surveyed, only 11% had read a book or journal article about infidelity. This is a staggering statistic considering that the number of couples presenting infidelity at the onset of therapy and the number of couples that disclose infidelity during treatment (total of 60%) is so large. This additional information as part of the scale has the potential to more accurately discriminate those with CEI and those without.

The PEI and FOHI variables yielded no main effect. This was surprising given that the anecdotal literature (Brown, 1991; Silverstein, 1998) goes to great lengths to caution therapists about their role in the treatment of infidelity, especially their biases. The PEI questions should be revised to better take into account the social desirability needs of the respondents. It appears that as to the first three questions on this scale, the respondents were less than totally open and truthful. This problem is prevalent in sexuality research (Bullough, 1986).

As with CEI, PEI can be greatly enhanced by reworking the way the variable is measured. Separating the questions into two parts so as to clarify if the betrayer, betrayed, or other man/other woman is the clinician himself/herself or his/her partner can greatly change the way the clinician is impacted by the experience. Also, adding questions to the scale that address what the clinician learned about disclosure in light of his/her own experience with infidelity in his/her own relationship (especially if it is known if he/she is the betrayer, betrayed, or other man/other woman) could offer a clearer picture of what actually impacts that clinician's Infidelity Perspective in his/her work. Similarly, learning what the experience of affairs in the clinician's family of origin

(FOHI) actually was and what the impact the affair had on the family and its members, especially the clinician, can clarify its impact.

- The study itself lends itself to future research. Several ideas are presented. Modify the study so that each of the original types of affairs (emotional, sexual, and emotional-sexual combination) is studied independently.

- Modify the IPS and the ICD-Q, implementing the suggestions for improving instrumentation gathered from expert opinion and, despite their recommendation to collapse the three types of affairs (emotional, sexual, combination emotional-sexual) into one, proceed with asking the respondents to differentiate among the three types of affairs. A larger sample (expert opinion included only 11 clinicians) might yield different results, especially in light of already existing research as presented by Glass (2002).

- Modify the IPS by asking the dilemmas in conjunction with the temporal aspects of affairs, such as current affair, affairs in the immediate past, and ancient affairs. It is conceivable that clinicians' perspectives on disclosure could change drastically from the ones discovered here if the affair(s) is/are part of the past of the couple.

- Design a study that measures the independent variable of gender and its impact on disclosure by collecting demographic information that accurately reflects the maleness or femaleness of a clinician from a socially constructed perspective based on a constellation of tendencies towards maleness and femaleness. This would hone in on other clinician traits pertinent to gender rather than simply his/her biological ones.

- Use the dilemmas in the IPS as springboards to new surveys—one survey per dilemma and collect from the sample all of their responses to that vignette.

- Create an exhaustive response set (first by utilizing all of the write-in responses from this study) and collecting additional responses (perhaps using a modified Delphi Study methodology) from a new sample of participants. This would enable our profession to develop a list to use for creating protocols for best practices for the treatment of infidelity.

- Using the IPS, study the differences between what clinicians do versus what they think they would do when faced with that dilemma. The benefit of this information is that it lends itself to comparing perceived with actual actions,

- Conduct this study with a larger sample to be able to examine three and four way interactions (having large enough numbers) of the variables of G, CEI, PEI, and FOHI.

- Review the many aspects of the data gathered by the IPS and ICD-Q and plan other analyses. Conduct this study with a larger sample so as to be able to examine the effects of spiritual/religious leaning, theoretical orientation, diversity, sexual orientation and sexual experience on clinicians' tendencies to promote the disclosure of affairs during therapy. A larger sample would provide adequate numbers in each of the cells in the design so that multiple interactions can be examined and confounding variables more easily controlled.

- For each of the independent variables (G, CEI, PEI, & FOHI), conduct a t-test and/or a within-subject analysis to be able to hone in more precisely on their impact on clinicians' tendencies to promote disclosure.

- Conduct a Modified Delphi Study and accumulate data that would lend itself to the creation of a manual on the Best Practice Strategies for the treatment of infidelity in clinical practice.

- Design research studies that measure treatment outcomes of the various interventions that are recommended by both the anecdotal and the research literature. Perhaps incorporating in the design the theoretical orientation of the therapist conducting the treatment.

Limitations of the Study

Potential limitations of the study existed with regard to adequacy of instrumentation and participating counselors' and therapists' response errors. Bias may have been created due to the characteristics of those clinicians who chose to participate in the study. No information is available with regard to why those who did not participate chose not to. Perhaps the instruments were too lengthy, the questions too cognitively challenging, the topic too personal, or the venture too overwhelming.

Given that the IPS and the ICD-Q were instruments to be self-administered, a possible second source of bias might have been created by the way each participant interpreted the directions, notwithstanding the vast improvements made to the instruments following the pilot study. The fact that the directions were written out in detail reduced the potential for this type of error.

Despite the pretesting of the items and the multiple rounds of rigorous scrutiny, the quality of the instruments was not optimal inasmuch as external criterion validation did not take place. Perhaps asking participants to complete some form of valid and reliable inventory that measures a trait such as authoritarianism, locus of control, assertiveness, or leadership, and determining the level of that trait in the clinician and then comparing it to the IPS score, could prove fruitful.

A limitation of this study is that, as in many research studies that deal with sexuality issues (even though infidelity has a much larger scope than just sex), the question of who tends to respond to these types of questionnaires is critical. Although the study was large enough to conduct the analyses sought (N-227), it is notable that only 270 questionnaires out of 1000 mailed were returned, and only 217 were usable. Although some of this lack of response may be attributed to the length of the questionnaires (each contained 9 pages) and to the fact that clinicians tend to be busy professionals, in reflecting on the demography of the sample itself, it is interesting to note the possibility that two cultures of responding clinicians exist. Perhaps those clinicians who tend to be more liberal or more conservative are more apt to participate in a study such as this, and so do not really reflect the population of the AAMFT clinical members. The sample indicates that of those responding, 50% and 26%, respectively, consider themselves liberal or moderate in their religious/spiritual leaning, and 16% consider themselves conservative. The majority of the sample (50%) tends to be liberal . . . is this true for the clinical population or just for those clinicians who tend to respond to a study such as this? Also of interest is the fact that of those responding, 23% have had only one lifetime sexual partner and 20% have had between 11 and more than 25 lifetime partners. Although not examined here, it is possible that the clinicians who

responded to this study may have strong opinions about the way infidelity should be addressed in clinical work and might be more motivated to participate, and so might not be totally representative of the AAMFT clinical population.

A final consideration that may affect the interpretation of the resulting data is the need to distinguish between statistical and practical significance. This is important in the field of social research. Bridging the gap between impressive numerical values and their application in the therapy room is a goal of those researching social/issues (Jacobson, 1985).

Despite the lack of significant results in the effect of gender, clinical experience, personal experience, and family of origin experience with infidelity on counselors' and therapists' tendencies to facilitate the disclosure of an affair as part of couples therapy when looked at individually, my clinical intuition leads me to believe that this is not the case. More likely, with an improved research design, more scrutiny to and fine-tuning of instrumentation, a refined way to measure the independent variables, and a more narrow focus on the study, more statistical significance might result for these independent variables, both when studied as main effects and when analyzed for interaction.

Conclusion and Closure

The first goal was to develop a valid and reliable scale that measures clinicians' levels of tendency to promote disclosure when faced with the suspicion or the knowledge of the existence of an affair in the relationship of couples in their care. Although with some limitations, the goal was accomplished. Following the designing of the IPS scale, it was deemed valid and reliable. It performed well in the study and produced a great deal of both qualitative and quantitative data. With some fine-tuning, the instrument can become more effective for future uses.

The second goal was to assess, identify, and report those actions therapists and counselors take when faced with the suspicion or the knowledge of the existence of a secret affair in the relationship of couples those clinicians are treating or considering treating.

This goal was also accomplished. In addition to being able to assert that clinicians engage in those activities presented in the response set, they also reported additional activities they engage in as they practice therapy. Specifically, they tend to explore their suspicions about affairs in individuals and couples with both partners present, tend to encourage suspicious partners to discuss their suspicions in conjoint sessions, and tend to facilitate discussions pertaining to the intended use of "discovered" information, especially the ramification of affirming the existence of affairs.

Furthermore, therapists tend to intervene by facilitating discussions pertaining to lack of trust in the couple's relationship. Many therapists avoid the issue of disclosure of an affair altogether by not granting individual sessions to members of a couple that the clinician has been treating in conjoint therapy. Or if the same clinician has been treating the individual, that clinician's policy is to refer the couple to another therapist in lieu of treating that couple himself/herself. Additionally, some clinicians make the determination to promote disclosure based on when the affair took place (in the past or in the recent past, or currently), and if the betrayed is terminally ill. Many clinicians adhere to a strict "No Secrets" policy that is shared at the beginning of couples therapy. Others facilitate discussion of why the betrayer wants to tell. If the reasons are self-serving, the clinician might not promote disclosure.

With regard to the type of information to be shared, the clinician allows the betrayed to decide how much information he/she wants to know, why he/she wants to know, and what will he/she do with the information once learned.

Still, some therapists seem to help clients decide how much information to share with children and extended family contingent on what the children and family members already know and on what is gained by the sharing. Others discourage sharing any information about the affair(s) with children and extended family so as to respect generational boundaries and to preserve privacy.

The third goal was to determine, analyze, and report how clinicians' gender, clinical/professional experiences with infidelity (CEI), personal experiences with infidelity (PEI), and family of origin experiences with infidelity (FOHI) influence their positions on whether or not an affair must be unearthed or disclosed as part of couples therapy.

This goal was also accomplished. It was determined that gender, clinical experience, personal experience, and family of origin experience each alone does not affect clinicians' positions on whether on not an affair must be unearthed or disclosed as part of couples therapy. It was also determined that when Gender and PEI and CEI and PEI interact, they create an effect on the clinician's tendency to facilitate the disclosure of an affair as part of couples therapy.

In addition to the above goals, and in keeping with Jacobson and Gurman's (1995) suggestion regarding the need to bridge the gap between research and clinical practice, it was the hope of this researcher/clinician that the following objectives would also be accomplished as a by-product of this research initiative:

- To expose clinicians to real-life scenarios that are part of the treatment of infidelity so that the scenarios would stimulate their thinking as they consider their actions when faced with each dilemma presented in the questionnaire.

- To encourage clinicians to think about whether or not they tend to come to their therapy rooms with unproductive biases and actions based on moralistic attitudes or rigid posturing.

- To disseminate the results into the public domain of the clinical community so that it might be used for treatment-planning, teaching, training, writing, personal development, and further research.

- To augment the academic dialogue that places infidelity on higher ground within the identified clinician training needs—and perhaps be seen as an issue with the same need for focus in couples work as domestic violence and substance abuse.

- To assist clinicians in entering their therapy rooms with less bias and judgmental attitude by beginning the cognitive restructuring process necessary that will enable them to conceptualize infidelity (for clinical purposes) as a neutral phenomenon, socially constructed, and viewed in the context of the evolution of love and committed relationships over time.

- To identify a research agenda for future studies on infidelity (perhaps, in part, using the write-in responses provided by the participating clinicians).

Based on respondents' oral and written comments throughout the process of the study (expert group, pilot group, and main study group; N = 275), several of the by-product objectives were accomplished. Specifically, clinicians were indeed exposed to real life scenarios about infidelity. They read the 11 dilemmas on the IPS and contemplated the 62 responses provided. Additionally, they added other responses reflecting their professional experience.

The results of this study have not yet been disseminated to the clinical community. As this part of the initiative (dissertation) comes to a close, the results will be posted in this writer/clinician's website. And, so that the dialogue started here will continue, additional writings using the data collected are envisioned.

A formal advocacy plan for placing the issue of infidelity on higher ground within the training needs of clinicians and elevating the focus on infidelity clinical work to a similar level as that of domestic violence and substance abuse has not yet been made. Perhaps as we collectively learn about the devastating impact of affairs on families as per the findings of Whisman, Dixon, and Johnson (1997), we will all come together to ameliorate first the way we intervene (with more awareness, knowledge, and skills), and then to raise our standards for determining what and how well we accomplish our work. More empirical (both qualitative and quantitative) outcome studies that have practical application are needed.

Ideas for further research have been presented earlier in this chapter. The impact of the IPS and other information in this project has not been determined yet with regard to if it/they encouraged the participants to think about their biases, moralistic attitudes, or rigid posturing as they enter their therapy rooms. Nor has it been determined if the IPS and the other information has assisted the participants to begin approaching their clients with less bias or judgmental attitudes as a result of their cognitions having changed—to make these determinations, more conversations, either in writing or in some other method of communication, is needed. It is the hope and wish of this researcher that we all keep talking to each other and that we all keep on sharing what we do, what works, what does not work, etc., as we work in our therapy rooms.

In conclusion, this initiative was an enlightening and interesting one. The processes enabled members of the Marriage and Family clinical community to communicate through verbal and written responses. The massive amounts of information and data gathered lend themselves to many more analyses and insights that will

contribute important knowledge to the collective wisdom of therapists. It is the intent of this researcher/clinician to continue facilitating this dialogue.

APPENDIX A
COVER LETTER/INVITATION TO PARTICIPATE

September 25, 2003

Dear Colleague:

I am a doctoral candidate in Counselor Education (MFT) at the University of Florida and am conducting research on infidelity for my dissertation. I am also a practicing clinician in Daytona Beach, Florida, and have been a clinical member of AAMFT since 1991. I care greatly about the work we do and I believe that it is incumbent upon us to share what happens in our therapy rooms with the rest of the clinical community so that each of us may benefit from the collective wisdom produced by our clinical experiences.

As someone who specializes in couples work, I am well aware of the difficulties and the clinical dilemmas that clinicians face each day when making decisions about client issues. Infidelity is one such issue. It is believed that therapists view the traumatic impact of infidelity on families as second only to the traumatic impact of physical violence on families (Whisman, Dixon, & Johnson, 1997). Despite the importance of the issue of infidelity in the treatment of families and couples, research on the subject is scarce. The purpose of this research initiative is to bring to light additional information about infidelity, focusing on how we, the clinicians, handle the issue of disclosure, and on what factors influence our decision-making.

I am writing to ask for your collaboration and participation in this initiative. Attached are two questionnaires designed for this study, together with a pre-addressed, pre-stamped envelope. *As a participant, your task is to complete both questionnaires and mail them back to me in a timely fashion. I ask that you do so within two weeks of receipt.* Please complete the Infidelity Perspective Survey (IPS) first, and then the Infidelity - Clinician Demographic Questionnaire (I-CDQ). You will note that the I-CDQ asks for personal information that I hope will not be offensive in any way. Your honesty will be greatly appreciated. Please note that all responses are anonymous.

Your returned, completed, questionnaires will constitute your consent to the inclusion of your responses in this study. Please know that the identity of participants will be kept confidential to the extent provided by law. The results of the study will be revealed throughout the dissertation process and will more than likely be published. You do not have to answer any questions that you do not wish to answer and you have the right to withdraw at any time, without consequences.

Following the defense of my dissertation, I will post the results of the study on my website, www.RosariaCUpchurch.com, which you can access currently if you wish to know more about me and my professional and community involvements. The website also contains a list of websites and academic references on infidelity.

Should you have any questions about this research project, please feel free to contact the Chair of my Supervising Committee: Dr. Silvia Echevarria-Doan, in the Department of Counselor Education at the University of Florida, at 352-392-0731, ext. 237. Questions or concerns about research participants' rights may be directed to the UFIRB Office, University of Florida, by mail to P.O. Box 112250, Gainesville, FL 32611-2250, and by telephone at (352) 392-0433.

Thank you for your consideration and assistance. I look forward to sharing the results with you and the rest of the clinical community soon.

Best regards,

Rosaria Carlone Upchurch, M.Ed., LMFT

APPENDIX B
INFIDELITY PERSPECTIVE SURVEY (IPS)—MAIN STUDY

INFIDELITY PERSPECTIVE SURVEY
(IPS)

DIRECTIONS

The IPS includes a series of dilemmas frequently encountered in the course of couples therapy . . . together with actions that might be taken by a clinician or therapist in response to each. For each situation / dilemma set forth, please indicate how frequently you have taken the action described when faced in practice with the particular dilemma, or how frequently you believe you would take the action (based upon clinical intuition) if you have not faced the particular dilemma. Please be sure to fill in "other" with actions that you have taken that are not already listed.

If you have not encountered a particular dilemma, please put an "X" in the box to the right of the dilemma description ***and then respond to each statement as you believe you would if faced with the dilemma.***

The following definition is provided to clarify the meaning of "an affair" as used in this survey.

Affair. A relationship that can be short-term or long-term and is defined by the presence of an emotional and/or physical attachment/behaviors between two people, one or both of whom are involved in an exclusive relationship with someone else. The affair relationship may include some or all of the following: secrecy; emotional intimacy; sexual chemistry; flirtatious or passionate kissing; petting; sexual intercourse; anal sex; oral sex; mutual masturbation; masturbation using the affair partner for visual and/or in-person stimulation; or using pornographic materials, chat rooms, exchanging erotic pictures of self, etc. ***without the primary partner's knowledge or agreement/endorsement. The key to defining the relationship an affair is the fact that all or parts of the affair relationship remain a secret from the committed partner(s)***. The relationship is an affair if it violates the contract/agreement for exclusivity and openness of communication (truthfulness) made by the committed relationship partners to one another. Affairs may take place over the Internet, on the telephone, in the workplace, etc.

Infidelity Perspective Survey (IPS)

A. COMMON DILEMMAS IN THERAPY When faced with each situation that follows, please indicate how frequently you have taken or would take the action reflected in each statement (by circling the correct number to the right of the statement). ***If you have not encountered a particular dilemma, please put an "X" in the box to the right of the dilemma description and respond to each statement as you believe you would if faced with the dilemma.*** *(Please be sure to fill in "other" with actions you have taken that are not already listed.)*	Never or almost never (1)	Some of the time (2)	Most of the time (3)	All of the time (4)

Please respond to all items.

1. In couples therapy, when you suspect one of the partners is involved in an affair, you …	*No experience with this dilemma - answers reflect what I would do* ☐			
a Confront him/her (eg., discuss it, explore it, etc.).	1	2	3	4
b Confront him/her (discuss it, explore it, etc.) in an individual session.	1	2	3	4
c Confront him/her (discuss it, explore it, etc.) on the telephone.	1	2	3	4
d Confront him/her (discuss it, explore it, etc.) in a conjoint session with his/her partner.	1	2	3	4
e Watch for signs of confirmation … and wait to do anything further.	1	2	3	4
f Do nothing. Your suspicions are not relevant to the process of therapy.	1	2	3	4
g Other:				

Please respond to all items.

2. In couples therapy, when *a partner* suspects the other of an affair and wants your direction on whether or not to spy on his/her partner (i.e., to take measures, such as taping conversations or hiring a private detective, to uncover the suspected affair), you …	*No experience with this dilemma - answers reflect what I would do* ☐			
a Encourage him/her to "go for it!"	1	2	3	4
b Advise him/her that it's up to him/her (perhaps facilitate discussion and decision).	1	2	3	4
c Encourage him/her to be more trusting and to let it go.	1	2	3	4
d Advise him/her that you have no opinion on the subject.	1	2	3	4
e Other:				

A. COMMON DILEMMAS IN THERAPY

When faced with each situation that follows, please indicate how frequently you have taken or would take the action reflected in each statement (by circling the correct number to the right of the statement). ***If you have not encountered a particular dilemma, please put an "X" in the box to the right of the dilemma description and respond to each statement as you believe you would if faced with the dilemma.*** *(Please be sure to fill in "other" with actions you have taken that are not already listed.)*

		Never or almost never (1)	Some of the time (2)	Most of the time (3)	All of the time (4)
Please respond to all items.					
3.	When moving from *individual* therapy to *couples* therapy, where the individual has disclosed his/her affair during individual therapy, you …	*No experience with this dilemma - answers reflect what I would do*			☐
a	Insist on disclosure prior to beginning couples therapy.	1	2	3	4
b	Encourage the client not to reveal the affair to his/her partner.	1	2	3	4
c	Leave it up to the client as to whether or not to disclose.	1	2	3	4
d	Gain a commitment from the individual that the affair will be discussed within a reasonable time from the commencement of couples therapy.	1	2	3	4
e	Refer the couple to another therapist	1	2	3	4
f	Other:				
Please respond to all items.					
4.	During couples therapy, one partner asks for an individual session. You grant the session and his/her affair is disclosed. You ...	*No experience with this dilemma - answers reflect what I would do*			☐
a	Tell the betraying partner that you expect him/her to share the information with his/her partner within a reasonable period of time.	1	2	3	4
b	Make a plan with the betraying partner for disclosure at the earliest possible opportunity in a conjoint session.	1	2	3	4
c	Suspend conjoint therapy until the betraying partner has suspended, ended, or disclosed the affair to his/her mate.	1	2	3	4
d	Ignore it or let the client decide whether or not to disclose to his/her mate.	1	2	3	4
e	Other:				

A. COMMON DILEMMAS IN THERAPY

When faced with each situation that follows, please indicate how frequently you have taken or would take the action reflected in each statement (by circling the correct number to the right of the statement). ***If you have not encountered a particular dilemma, please put an "X" in the box to the right of the dilemma description and respond to each statement as you believe you would if faced with the dilemma.*** *(Please be sure to fill in "other" with actions you have taken that are not already listed.)*

	Never or almost never	Some of the time	Most of the time	All of the time
	(1)	(2)	(3)	(4)

Please respond to all items.

		No experience with this dilemma - answers reflect what I would do			☐
5.	During couples therapy, either through an individual session and/or through another means of direct reporting/admission by the betraying partner, you and the betraying partner agree that an affair is to be disclosed to the betrayed partner. He/she wants to wait to disclose the affair. You …				
a	Wait indefinitely and continue conjoint therapy … it's his/her call.	1	2	3	4
b	Set a deadline by which time the affair must be disclosed or ended … or conjoint therapy will terminate.	1	2	3	4
c	Set a deadline by which time the affair must be disclosed or the course of therapy will change.	1	2	3	4
d	Stop conjoint therapy and offer the partners individual therapy.	1	2	3	4
e	Other:				

Please respond to all items.

		No experience with this dilemma - answers reflect what I would do			☐
6.	You are coaching the *betraying partner* on ways to make disclosure to the *betrayed partner* about his/her affair. How much information do you recommend be shared with his/her partner?				
a	Admit to the affair.	1	2	3	4
b	Only important facts.	1	2	3	4
c	All details about expenditures.	1	2	3	4
d	All details about gifts, I love you's, etc.	1	2	3	4
e	All details about any possible Sexually Transmitted Infections.	1	2	3	4
f	All details pertaining to the occurrence of pregnancy.	1	2	3	4
g	All details pertaining to the births of any children.	1	2	3	4
h	All information pertaining to who knows about the affair (friends, family, etc.).	1	2	3	4
i	All information pertaining to the places that the rendez-vous occurred.	1	2	3	4
j	All information pertaining to what activities took place in the marital/relationship home.	1	2	3	4
k	None … or as little as possible.	1	2	3	4
l	Discourage disclosure altogether.	1	2	3	4
m	Ask the betrayed partner how much he/she wants to know.	1	2	3	4
n	Let the betraying partner decide how much he/she wants to share.	1	2	3	4
o	Other:				

A. COMMON DILEMMAS IN THERAPY

When faced with each situation that follows, please indicate how frequently you have taken or would take the action reflected in each statement (by circling the correct number to the right of the statement). ***If you have not encountered a particular dilemma, please put an "X" in the box to the right of the dilemma description and respond to each statement as you believe you would if faced with the dilemma.*** *(Please be sure to fill in "other" with actions you have taken that are not already listed.)*

	Never or almost never (1)	Some of the time (2)	Most of the time (3)	All of the time (4)
Please respond to all items.				
7. In couples therapy, one partner suspects his/her partner is having an affair, believes you may know about it (and you do), and asks you directly if his/her partner is having the affair. You …				*No experience with this dilemma - answers reflect what I would do* ☐
a Avoid telling the truth.	1	2	3	4
b Tell the truth.	1	2	3	4
c Ask him/her to ask his/her partner.	1	2	3	4
d Say … "That's not for me to answer."	1	2	3	4
e Refer the couple to another therapist.	1	2	3	4
f Tell him/her that confidentiality prohibits you from discussing it.	1	2	3	4
g Other:				
Please respond to all items.				
8. During couples therapy, where either through an individual session and/or through another means of direct reporting/admission you learn the betraying partner wants to disclose his/her affair to the betrayed partner, you …				*No experience with this dilemma - answers reflect what I would do* ☐
a Point out the risks involved in disclosing the affair.	1	2	3	4
b Encourage disclosure without reservations.	1	2	3	4
c Point out the advantages of disclosing the affair.	1	2	3	4
d Discourage disclosure … point out the disadvantages.	1	2	3	4
e Other:				
Please respond to all items.				
9. In couples therapy, when you are aware of an affair and, even though no history of violence is present, you believe violence could result from disclosure, you …				*No experience with this dilemma - answers reflect what I would do* ☐
a. Discourage any type of disclosure of the affair for fear of someone getting hurt.	1	2	3	4
b. Encourage disclosure under certain conditions of safety/safety planning.	1	2	3	4
c. Require disclosure of the affair for therapy to continue … irrespective of possible violence.	1	2	3	4
d. Insist on no disclosure.	1	2	3	4
e. Other:				

A. COMMON DILEMMAS IN THERAPY When faced with each situation that follows, please indicate how frequently you have taken or would take the action reflected in each statement (by circling the correct number to the right of the statement). ***If you have not encountered a particular dilemma, please put an "X" in the box to the right of the dilemma description and respond to each statement as you believe you would if faced with the dilemma.*** *(Please be sure to fill in "other" with actions you have taken that are not already listed.)*	Never or almost never (1)	Some of the time (2)	Most of the time (3)	All of the time (4)

Please respond to all items.

10.	In couples therapy, the couple asks advice on whether or not to tell their children about an affair. You ...	*No experience with this dilemma - answers reflect what I would do* ☐			
a	Encourage them to tell nothing to the children.	1	2	3	4
b	Encourage them to wait to decide whether or not to tell the children.	1	2	3	4
c	Encourage them to tell the adult (*over 21 years of age*) children.	1	2	3	4
d	Encourage them to tell the older (*ages 13-21 years*) children.	1	2	3	4
e	Encourage them to tell the younger (*under 13 years of age*) children.	1	2	3	4
f	Explore their motives for wanting to tell and then advise them.	1	2	3	4
g	Other:				

Please respond to all items.

11.	In couples therapy, the couple asks advice on whether or not to tell their extended family about an affair. You ...	*No experience with this dilemma - answers reflect what I would do* ☐			
a	Encourage them to disclose everything immediately.	1	2	3	4
b	Encourage them to disclose nothing. It's nobody's business.	1	2	3	4
c	Encourage them to disclose to some of their family members as they see fit.	1	2	3	4
d	Encourage them to wait to disclose until they can decide what information they want to disclose.	1	2	3	4
e	Explore their motives for wanting to tell and then advise them.	1	2	3	4
f	Other:				

B.	Personal Beliefs Please circle the number to the right of each statement below that most closely reflects your belief regarding the statement.	Never or almost never (1)	Some of the time (2)	Most of the time (3)	All of the time (4)
	Your view of affairs / extramarital / extrarelationship sex				
a	You see affairs as a defense maneuver in the interpersonal pattern of the relationship.	1	2	3	4
b	You see affairs as an acting-out of unconscious conflicts.	1	2	3	4
c	You see affairs as a harmless dalliance.	1	2	3	4
d	You see affairs as a relationship stabilizer.	1	2	3	4
e	You see affairs as an attempt to solve a problem in the marriage/relationship.	1	2	3	4
f	You see affairs as a way to fulfill sexual needs primarily.	1	2	3	4
g	You see affairs as a way to fulfill emotional needs primarily.	1	2	3	4
h	You see affairs as a way to fulfill both sexual and emotional needs.	1	2	3	4
i	You see affairs as a way to fulfill unmet needs in the primary relationship.	1	2	3	4
j	You see affairs as the betrayer's way out of his/her primary relationship.	1	2	3	4
k	You see affairs as an addiction problem.	1	2	3	4
l	You see affairs as a behavior resulting from the betrayer's character flaws.	1	2	3	4
m	You see affairs as a behavior that is part of the human condition…neither good or bad…just there.	1	2	3	4
n	You believe that if an affair takes place, the couple should divorce.	1	2	3	4
o	You think that if a secret affair is present, it should be surfaced and disclosed during therapy.	1	2	3	4
p	You think that if a secret affair is present, the therapist should not get involved with its disclosure.	1	2	3	4

C. Professional Practices With Infidelity Please circle the number to the right of each statement below that most closely reflects your belief regarding the statement.	Never or almost never (1)	Some of the time (2)	All or most of the time (3)
1. Based upon your clinical / professional experience with the effects of disclosure on the following types of clients, how often do you now promote the disclosure / discovery of a secret affair in a relationship?			
a Individual Therapy with the betrayer	1	2	3
b Individual Therapy with the betrayed	1	2	3
c Couples Therapy involving a male betrayer	1	2	3
d Couples Therapy involving a female betrayer	1	2	3
2. Based upon your experience with the effects of disclosure, how often, prior to disclosure, do you now …			
a Assess for sexual addiction?	1	2	3
b Assess for other addictions (gambling, spending, etc.)?	1	2	3
c Assess the potential for suicide by either partner?	1	2	3
d Assess the potential for homicide by either partner?	1	2	3
e Assess the potential for violence by either partner?	1	2	3
f Assess the presence of substance use/abuse by either partner?	1	2	3
g Assess the presence of homosexuality/bisexuality in either partner?	1	2	3
h Assess the existence of prior incidences of infidelity/affairs in either partner's behavior?	1	2	3
I Assess for chidhood sexual abuse?	1	2	3
I Determine if a protective environment is needed by either of the partners?	1	2	3
k Schedule individual sessions for each partner following disclosure?	1	2	3
l Refer the clients to a clinic or a doctor so that they might be tested for Sexually Transmitted Infections?	1	2	3
m Enter into a "no secrets" contract with clients?	1	2	3
n Pray with your cients?	1	2	3
o Other:			
3. Based upon your clinical experience with disclosure, please select the appropriate response …			
a Disclosure creates positive outcomes in therapy.	1	2	3
b Disclosure creates negative outcomes in therapy.	1	2	3
c I require disclosure.	1	2	3
d I facilitate disclosure.	1	2	3
e I let the client decide about disclosing.	1	2	3

C. Professional Practices With Infidelity Please circle the number to the right of each statement below that most closely reflects your belief regarding the statement.		Never or almost never (1)	Some of the time (2)	All or most of the time (3)
4.	Based upon your professional experience with infidelity, how often, following disclosure, did the client(s) ...			
a	Threaten to leave the relationship?	1	2	3
b	Leave the relationship?	1	2	3
c	Become psychotic or extremely emotionally unstable?	1	2	3
d	Threaten suicide?	1	2	3
e	Attempt suicide?	1	2	3
f	Commit suicide?	1	2	3
g	Threaten homicide?	1	2	3
h	Attempt homicide?	1	2	3
I	Commit homicide?	1	2	3
j	Threaten violence towards others?	1	2	3
k	Become violent towards his/her partner?	1	2	3
l	Become violent towards you?	1	2	3
m	Become violent towards the other man/woman?	1	2	3
n	Become hospitalized?	1	2	3
o	Go to a protective shelter?	1	2	3
p	End therapy abruptly?	1	2	3
q	Regret disclosing?	1	2	3
r	Sue you for forcing disclosure?	1	2	3
s	Sue you for keeping the affair secret?	1	2	3
t	Go to jail?	1	2	3
u	Disclose homosexuality/bisexuality at the same time as the affair?	1	2	3
v	Discover that he/she/they was/were not the biological parents of the children?	1	2	3
w	Divorce happily?	1	2	3
x	Separate happily?	1	2	3
y	Remain together happily?	1	2	3
z	Remain together and create a stronger/more loving relationship?	1	2	3
aa	Report being glad about having disclosed?	1	2	3
bb	Report being glad about his/her partner's having disclosed?	1	2	3
cc	Report relief over having disclosed?	1	2	3
dd	Enter recovery programs (alcohol, etc.)?	1	2	3

APPENDIX C
INFIDELITY: CLINICIAN DEMOGRAPHIC QUESTIONNAIRE
(I-CDQ)—MAIN STUDY (EXCERPT)

For each item appearing below, please check and/or fill in the appropriate box as it pertains to you.

I. Professional Profile

*Academic Degrees Earned (check **all** that apply)*

_____ Bachelors
_____ Masters of Science, Arts, or Education
_____ Masters of Social Work
_____ Masters of Divinity
_____ Doctorate of Divinity
_____ Doctorate of Philosophy (Ph.D)
_____ Doctor of Medicine
_____ Other:

*Licensures Held (check **all** that apply)*

_____ Psychologist
_____ Marriage & Family Therapist
_____ Mental Health Counselor
_____ Clinical Social Worker
_____ Pastoral Counselor
_____ Christian Counselor
_____ Medical Doctor
_____ Other:

*Professional Affiliations (check **all** that apply)*

_____ American Association of Marriage and Family Therapy (AAMFT)
_____ American Psychological Association (APA)
_____ National Association of Social Workers (NASW)
_____ American Counseling Association (ACA)
_____ National Association of Mental Health (NAMH)
_____ National Association of Christian Counselors (NACC)
_____ National Association of Pastoral Counselors (NAPC)
_____ Other:

*Specialized Training Received / Certifications (check **all** that apply)*

_____ Sex Therapist
_____ Sex Educator
_____ IMAGO Relationship Therapist
_____ Gottman Therapist
_____ Mars & Venus
_____ Passionate Marriage (Crucible)
_____ Hot Monogamy
_____ Emotion Centered
_____ Solution Focused
_____ Alcohol / Addiction Counselor
_____ Trauma Counselor
_____ Grief Counselor
_____ AAMFT Approved Supervisor
_____ Other:
_____ Other:

IV. Clinical / Professional Experience with Infidelity

A. What populations do you work with? *(check **all** that apply)*

____ Couples	____ Adolescents *(age 13-18 years)*
____ Individuals	____ Adults
____ Groups	____ Geriatics
____ Families	____ Other:
____ Children *(age 0-12 years)*	____ Other:

B. Approximate number of ***cases*** in your career involving infidelity (couples and individuals):

____ 0 - 100	____ 201 - 300	___ 401 - 500
____ 101 - 200	____ 301 - 400	___ more than 500

(The "betraying partner" is the partner involved in the extra-dyadic relationship, the "betrayed partner" is his/her partner, and the "other man/woman" is the person involved with the betraying partner in the extra-dyadic relationship)

C. Focus of Work with Infidelity

How frequently have you worked with ...	Never	Some of the time	Most of the time
Individual Therapy with the betraying partner	1	2	3
Individual Therapy with the betrayed partner	1	2	3
Individual Therapy with " the other woman"	1	2	3
Individual Therapy with " the other man"	1	2	3
Couples Therapy with a male betrayer	1	2	3
Couples Therapy with a female betrayer	1	2	3
Couples Therapy involving affairs on both sides	1	2	3
Heterosexual Couples Therapy involving a homosexual affair	1	2	3
Couples Therapy with Lesbian Couples	1	2	3
Couples Therapy with Gay Couples	1	2	3
Other (*please specify*):			

V. Personal History with Infidelity

Personal Experience with Infidelity

(The "betraying partner" is the partner involved in the extra-dyadic relationship, the "betrayed partner" is his/her partner, and the "other man/woman" is the person involved with the betraying partner in the extra-dyadic relationship)

Check the correct responses ...	No	Yes - openly	Yes - secretly
Are you or your partner/spouse now a *betraying* partner?			
Are you or your partner/spouse now a *betrayed* partner?			
Are you or your partner/spouse now the other man / woman?			
Have you or your partner/spouse ever been a *betraying* partner?			
Have you or your partner/spouse ever been a *betrayed* partner?			
Have you or your partner/spouse ever been the other man / woman?			

Family of Origin History with Infidelity

Based upon knowledge and information, you believe that ... *(Circle the correct response)*		No, not to my knowledge	Suspect so	Know so	Don't know
Your mother (female caregiver) was or has been a/an	betraying partner	1	2	3	4
	betrayed partner	1	2	3	4
	other man/woman	1	2	3	4
Your father (male caregiver) was or has been a/an	betraying partner	1	2	3	4
	betrayed partner	1	2	3	4
	other man/woman	1	2	3	4
Your maternal grandmother was or has been a/an	betraying partner	1	2	3	4
	betrayed partner	1	2	3	4
	other man/woman	1	2	3	4
Your paternal grandmother was or has been a/an	betraying partner	1	2	3	4
	betrayed partner	1	2	3	4
	other man/woman	1	2	3	4
Your maternal grandfather was or has been a/an	betraying partner	1	2	3	4
	betrayed partner	1	2	3	4
	other man/woman	1	2	3	4
Your paternal grandfather was or has been a/an	betraying partner	1	2	3	4
	betrayed partner	1	2	3	4
	other man/woman	1	2	3	4

APPENDIX D
POSTCARD REMINDER

Rosaria C. Upchurch
P.O. Box 9127
Daytona Beach, FL 32120-9127

FIRST CLASS
US POSTAGE
PAID
PERMIT #15
WARRENTON, VA

Dear Colleague:

I recently sent you a packet containing TWO QUESTIONNAIRES, a cover letter, and a pre-addressed envelope. This postcard is a reminder and a request for you to please take the time to complete and return the two questionnaires. (If you have already done so ... THANK YOU!) I am looking forward to being able to learn from you about those actions you take when you are working with clients who struggle with infidelity. I APPRECIATE YOUR TIME AND GENEROSITY.

Thank You,

Rosaria C Upchurch, LMFT

Rosaria Carlone Upchurch
LMFT (University of Florida Doctoral Candidate).

If you have questions, feel free to contact me at RCU99@aol.com

APPENDIX E
COVER LETTER TO EXPERT MEMBERS, PROJECT GOALS, AND INSTRUCTIONS

Rosaria C. Upchurch, LMFT

123 Live Oak Avenue
Daytona Beach, FL 32114
Tel: 386-252-3414
Fax: 386-673-1651
E-Mail: RCU99@aol.com

Re: Group-Consensus Meeting
July 11, 2003
Dear Colleagues and Friends:

Thank you for agreeing to help me with my dissertation research. As you know, we will be meeting on July 22, 2003 to hold a group discussion and hopefully to share a good time with each other as we enjoy a yummy dinner prepared especially for us by the chef at the Cellar Restaurant located at 220 Magnolia Avenue, Daytona Beach, FL. The place will be closed to other patrons. I am very grateful that you are willing to take time out of your busy schedules to assist me this way. Based on the feedback from all of you, I have settled on a meeting time of 6:30PM. I hope you all will be comfortable with our discussion being audio and video recorded.

The meeting should last approximately 2.5 hours (including dinner). The goal of the meeting is to establish content validity for the questionnaires I will be using in my research, and to obtain your feedback on the quality of the questions, including the reaction(s) the questions elicit in you when you read them (especially in the I-CDQ document which asks very personal questions). Below are specific instructions for you to follow as you prepare for the meeting.

In addition to this letter to you and the agenda for the meeting, this packet contains the materials that you will need to review prior to the meeting. Specifically, included are: (1) The Infidelity Perspective Questionnaire (IPS); (2) The Infidelity: Clinician Demographic Questionnaire (I-CDQ); (3) The cover letter that will be part of the packet sent to the participants of the study; and (4) A worksheet for you to use as you review the IPS and the I-CDQ. Please bring everything ready to hand in with you to the meeting.

I look forward to seeing you all at the Cellar very soon. There is plenty of parking adjacent to the restaurant that is located close to Ridgewood on Magnolia Avenue.

Sincerely,

Rosaria Carlone Upchurch, LMFT
University of Florida Doctoral Candidate
Cell Phone Number: 386-316-8336
Participating Group Members

Rosaria Upchurch, LMFT Facilitator

Marie Bracciale, LMFT
Jane Devine, LMFT
Mark Harter, Ph.D.
Buddy Jowers, MSW
Karen Spicer, LMFT
Peggy Kennerley, Ph.D.
Robert Kennerley, Ph.D.
George Lindenfeld, Ph.D.
Cindy Goldberg Newman, LMFT
Jane Updyke, LMFT

DESCRIPTION AND GOALS OF THE STUDY

DISSERTATION NAME:

The Influence of Therapists' & Counselors' Personal and Professional Experiences with Infidelity on their Tendency to Dictate the Disclosure of Affairs as Part of Couples Therapy

PURPOSE OF THE INVESTIGATION:

The purpose of this investigation is to determine the actions clinicians take when they learn or suspect that a secret affair exists in the lives of the couples they treat or are about to treat, and how those clinicians' personal and professional experiences with infidelity influence the actions they take. Three goals are conceptualized.

1. To develop a valid and reliable scale, containing three sub-scales, that measures clinicians' level of tendency to dictate disclosure when faced with suspicion or knowledge of the existence of either an emotional, a sexual, or a combination emotional-sexual affair in the relationship of couples in their care.

2. To assess, identify, and report those actions therapists and counselors take when faced with suspicion or knowledge of the existence of a secret emotional, sexual, or combination emotional-sexual affair in the relationship of couples those clinicians are treating or considering treating.

3. To analyze, determine, and report how clinicians' personal and professional experiences with infidelity influence their positions on whether or not an emotional, a sexual, or a combination emotional-sexual affair must be unearthed or disclosed as part of couples therapy.

INSTRUCTIONS FOR GROUP-CONSENSUS MEETING PARTICIPANTS

1. Read the cover letter to research participants (Dated June 20, 2003).

2. On the back of the letter, please write/type any comments, reactions, and feedback pertaining to the letter's format, information, etc.

3. Complete the IPS questionnaire cover to cover. Time yourself and report how long it takes you to respond to the questions. Record the time on your worksheet before moving forward.

4. Complete the IPS worksheet per its instructions.

5. Complete the I-CDQ except for the section with the title " V. Personal History with Infidelity" pgs. 7-8. For this omitted section, please review the questions closely and

determine whether each subsection and its specific questions might in any way be offensive to clinicians who will be answering them anonymously.

6. Review each question on the I-CDQ for clarity, quality, and the ease with which you were able to respond to the item.

Thank you!!!!!

APPENDIX F
CONSENSUS GROUP WORKSHEET (EXCERPT)

WORKSHEET -- Infidelity Perspective Survey (IPS)

Name: _____ IPS completion time: _____

The purpose of the IPS questionnaire is (a) to determine the tendency of clinicians to dictate disclosure (as part of couples therapy) when faced with suspicion or knowledge of an affair in the relationship of couples in their care, and (b) to determine what specific actions clinicians are taking when faced with such suspicion or knowledge.

In view of this purpose of the IPS, please indicate below, for each of the eleven scenarios set forth in the IPS, the effectiveness / usefulness of the item described in serving that purpose.

Please circle the number to the right that most closely describes your response.	Agree strongly	Agree	Dis-agree	Don't know
1. For Questions 1A through 1C ... page 1				
a. This is a scenario that therapists are likely to encounter.	1	2	3	4
b. The list of possible therapists' actions (the "items") for this scenario is complete.	1	2	3	4
c. The items taken as a whole will enable the researcher to measure a respondent's tendency to dictate disclosure when faced with the suspicion or knowledge of an affair.	1	2	3	4
d. The items effectively measure ...				
(i) a respondent's tendency to dictate disclosure	1	2	3	4
(ii) a respondent's tendency to let the client(s) decide if disclosure is to take place	1	2	3	4
(iii) a respondent's tendency to be passive regarding dictating disclosure.	1	2	3	4
e. Please write suggested changes for this scenario directly on the IPS questionnaire.				

APPENDIX G
DILEMMA # 1: VERBATIM WRITTEN-IN RESPONSES

IPS Qualitative Data ("Other" responses—In addition to the responses provided in the IPS, the following information was written in by the respondent. All IPS were numbered sequentially upon receipt from survey respondents—the number in parenthesis below refers to the specific IPS from which the information was taken.)

Dilemma # 1: In couples therapy, when you suspect one of the partners is involved in an affair, you… (Responses provided: Confront his/her (e.g. Discuss it, explore it, etc./Confront his/her (discuss it, explore it, etc.) in an individual session/Confront him/her (discuss it, explore it, etc.) on the telephone/Confront him/her (discuss it, explore it, etc.) in a conjoint session with his/her partner/Watch for signs of confirmation…and wait to do anything further/Do nothing. Your suspicions are not relevant to the process of therapy/Other). Other:

1. Try to open space for fuller disclosure in conjoint session. (8)
2. Educate couple regarding the definition of infidelity and discuss it. (34)
3. Make some generalized references to affairs in situations like this. (36)
4. Work with each partner to explore the issue. I might ask in a conjoint session whether either of them has any reason to think there has been an affair. (78)
5. Listen and acknowledge client's view of his/her dilemma and then choose appropriate response to fully understand situation. (86)
6. Confront him/her (discuss it, explore it, etc.) and discuss the impact on future treatment. (96)
7. Suggest individual sessions if nothing is forthcoming in couple's session. (138)
8. Refuse to participate until affair is terminated and spouse is advised. (144)
9. Ask jointly if either has another involvement or individually say this saturation could make one vulnerable. (144)
10. Structure session so couple reveals it.
11. Depends if couple wants to try to stay together. (163)
12. Ask the partner if they suspect infidelity. (173)
13. Educate couple regarding inability to keep a secret. (187)
14. Confront his/her (e.g. Discuss it, explore it, etc.) if hints are dropped. (200)
15. Depends on focus of treatment. (211)
16. Discuss what it means. (212)

APPENDIX H
DILEMMA # 2: VERBATIM WRITTEN-IN RESPONSES

IPS Qualitative Data ("Other" responses—In addition to the responses provided in the IPS, the following information was written in by the respondent. All IPS were numbered sequentially upon receipt from survey respondents—the number in parenthesis below refers to the specific IPS from which the information was taken.)

Dilemma #2: In couples therapy, when a *partner* suspects the other of an affair and wants your direction on whether or not to spy on his/her partner (i.e. to take measures, such as taping conversations or hiring a private detective, to uncover the suspected affair, you…(Responses provided: Encourage him/her to "go for it!"/Advise him/her that it's up to him/her (perhaps facilitate discussion and decision)./Encourage him/her to be more trusting and to let it go./Advise him/her that you have no opinion on the subject/Other). Other:

1. Explore their intuition regarding the affair. (1)
2. Explore feelings regarding how the suspecting partner will feel if it is confirmed or not confirmed. (4)
3. Explore the issue.
4. Process what brings up the concern, attend to the response. (11)
5. Urge him/her to confront the partner and then facilitate. (21)
6. Don't address it. (27)
7. Explore readiness to deal with results of those measures. (33)
8. Encourage the partner to confront other during session. (34)
9. Encourage to discuss it openly with partner. (42)
10. Resist, questions about possible outcomes of such behaviors. (44)
11. Explore issues and practical approach to confronting, explore feelings, fears, etc. (46)
12. Explore suspicions further. (58)
13. Explore with his/her benefits of such risks, focus on self, how to manage. (59)
14. Explore hx, partners hx hurt issues in general, intuitive sense, encourage exploration of issues in couples work. (83)
15. Explore client's ideas and opinions as well as pros and cons of options. Perhaps brainstorm additional options and their impact on client's situation. (86)
16. Advise him/her that it's up to him/her (perhaps facilitate discussion and decision) in conjoint session. (89)
17. Advise him/her that he/she is "playing" with fire to take such measures. Discuss possible consequences of such behaviors. (96)
18. This all depends on whom I am working with. (99)

19. Advise that client look for reason for his/her suspicion and identify the motivation he/she has before taking active role. (104)
20. Encourage confrontation of issue. (106)
21. Point out potential consequences. (119)
22. Refocus (providing an affair is not the goal). (122)
23. Facilitate discussion in couple's session about what would need to be in place for trust to return. (126)
24. Renegotiate relationship with risk to trust but continue if no affair, if impasse is occurring. (127)
25. Suggest approaching partner first. If partner evades, lies, blows-up, etc. Those might be obstructing signals leaving no device but to get the truth indirectly. (138)
26. Would discuss options of confronting partner. (139)
27. I would have difficulty engaging in couple's therapy with this secret. (141)
28. Discuss directly confronting the spouse. (144)
29. Bring partner in and discuss suspicion. (156)
30. Encourage him/her to bring up the question in joint session. (167)
31. Request they discuss the concern in therapy. (173)
32. Explore why has the suspicions, validate. (179)
33. Explore what client's goals for getting information. Can it be accomplished in another way? (187)
34. Encourage him/her to talk to the partner. If possible bring the partner in to disclose suspicions and resolve the issues. (203)
35. Talk bout the problem of lack of trust and help clients empower self without loss of integrity. (200)
36. Discuss what it means. (211)
37. I don's see couples in individual sessions. (212)

APPENDIX I
DILEMMA # 3: VERBATIM WRITTEN-IN RESPONSES

IPS Qualitative Data ("Other" responses—In addition to the responses provided in the IPS, the following information was written in by the respondent. All IPS were numbered sequentially upon receipt from survey respondents—the number in parenthesis below refers to the specific IPS from which the information was taken.)

Dilemma # 3: When moving from *individual* therapy to *couples* therapy, where the individual has disclosed his/her affair during individual therapy, you…(Responses provided: Insist on disclosure prior to beginning couples therapy./Encourage the client not to reveal the affair to his/her partner./Leave it up to the client as to whether or not to disclose./Gain a commitment from the individual that the affair will be discussed within a reasonable time from the commencement of couples therapy./Refer the couple to another therapist./Other…). Other:

1. Couples therapy focuses on the "person of the marriage" formed by the two individuals…I tell them both this perspective from the beginning. (1)
2. I would certainly recommend but certainly not insist. (5)
3. Depends on if affair is ongoing (need commitment to end affair before I will begin couples therapy). (6)
4. Gain commitment to end the affair during couples therapy. (10)
5. Would refer to couples work. (11)
6. Depends on the nature of the affair (e.g. one time on a trip or a love affair) encourage to tell or refer out. (12)
7. I try to explore the meanings underneath the acting-out in an affair and discuss what needs to be shared with the spouse. (17)
8. I don't do individual therapy. (19)
9. Depends on many things. (27)
10. Depends on agenda of the couple if damage related to affair assigns guilt only (health concerns aside) of guilty party. (34)
11. Would never do this scenario. (39)
12. Discuss what would be involved in telling, determining if it is to relieve his/her own guilt, depends if the affair is ongoing. (44)
13. I don't usually change my contract from individual to couples. (48)
14. Would not move from individual to couples. (49)
15. Depends on whether the affair is terminated, time of the affair, frequency of affairs, etc. (56)
16. If couples won't disclose, I won't do couples therapy. (58)
17. I would need to know timing of the affair if current or ancient history. (59)

18. Encourage the client not to reveal only if partner is terminally ill or affair is 30 years old. (65)
19. Refuse to see together until client has ended affair. (65)
20. Explore what client wants to do in addressing this with partner and explain ethics of referral to avoid dual relationships. (86)
21. Insist on disclosure prior to beginning couples therapy if the affair is current. (89)
22. Encourage the client not to reveal the affair to his/her partner if the affair is past. (89)
23. Depends on who I am working with. (99)
24. No secrets policy. (119)
25. Encourage disclosure when appropriate my or may not be. (135)
26. I would not see the couple together unless individuals have agreed to taking steps to end affair. If it is a past affair, I might bring it into the present. (138)
27. It depends on how old the affair is whether it's ongoing or old. Finished affair many not need disclosing. (139)
28. Raise the issue on how my knowledge would affect therapy. (148)
29. Advise client to weigh the pros and cons of disclosure. If affair has ended and is in the past. (153)
30. Avoid individual therapy when couples issues prevail. (156)
31. If I have seen one member in individual therapy, I will rarely suggest they see a new therapist for couple therapy. (162)
32. Must be very good reason not to discuss…e.g. terminally ill, etc. (181)
33. I would usually not do individual and then couples therapy. (192)
34. Encourage and agree that the affair will cease during couples therapy. (199)
35. Depends on contract with couple and focus. That issue is clarified in the contract. (211)
36. I don't see individuals when couples refer. (121)

APPENDIX J
DILEMMA # 4: VERBATIM WRITTEN-IN RESPONSES

IPS Qualitative Data ("Other" responses—In addition to the responses provided in the IPS, the following information was written in by the respondent. All IPS were numbered sequentially upon receipt from survey respondents—the number in parenthesis below refers to the specific IPS from which the information was taken.)

Dilemma # 4: During couples therapy, one partner asks for an individual session, you grant the session and his/her affair is disclosed. You… (Responses provided: Tell the betraying partner that you expect him/her to share the information with his/her partner within a reasonable period of time./Make a plan with the betraying partner to disclose at the earliest possible opportunity in a conjoint session./Suspend conjoint therapy until the betraying partner has suspended, ended, or disclosed the affair to his/her mate./Ignore and let the client decide whether or not to disclose to his/her mate./Other.). Other:

1. Do not ignore it, client has a choice. (1)
2. I have an explicit policy about not keeping secrets, when I do, depends on if affair is current or past. (6)
3. Determine partner's level of commitment for keeping marriage and go from there. (10)
4. Depends on the nature of the affair. (12)
5. Ask that the betrayal be stopped at least during therapy explaining that with its continuation there will be no investment in the marriage. Disclosure is NOT the issue. (14)
6. Urge betraying partner to reveal infidelity in a joint session. (15)
7. Look at the dynamics and patterns that are acted out-in the affair. I encourage looking at the emotional secrets that have not been discussed in the marriage and not behavioral secrets of the affair. (17)
8. I don't grant this. (19)
9. I would probably not grant individual appointment during couples treatment. (21)
10. Avoid individual sessions when doing couples therapy. (33)
11. Affairs must stop or I won't see as couple again unless negotiating ending the relationship. (34)
12. Disclosure can be very dangerous. (35)
13. On a case-to-case basis, I would determine whether I could continue as therapist considering the intentions of betraying partner and other factors such as when, why, etc. (36)

14. Continue to work with the couple advising that affair makes the process less likely to help. If treatment is not helping, consider termination of couples treatment. (37)
15. Would never do this scenario. (39)
16. Refer him/her to individual therapy. (48)
17. Would not meet individually. (50)
18. I do not offer individual session when doing couples therapy. (68)
19. Give couples a disclosure form a the beginning of therapy that addresses this issue and provides information on how the therapist works. (78)
20. My disclosure covers this dilemma. (82)
21. Expect betraying partner to end the affair either before disclosing to spouse or immediately after disclosure. Suspend conjoint therapy if client refuses to end the affair. (85)
22. Do not grant such a session without forewarning couples at intake how such disclosures would be handled. (86)
23. Probably would not grant individual session. I don't want to hold any secrets. (97)
24. Deal with this issue in my opening session. (108)
25. Tell individual I can't continue with them as a couple while carrying a secret affair. Either individual can face up and tell spouse or I am unwilling to continue couples treatment or if neither…I would announce discomfort with couples treatment at next session. (138)
26. Depends on currency with affair if current, must stop or disclose or no therapy. If finished, depends on situation. (139)
27. I don't see partners individually. (140)
28. Would not grant individual session. (142)
29. Help betraying partner consider the best way to inform the other. (144)
30. Raise the issue of how the disclosure would best be dealt with and affect therapy. (148)
31. IF violence or revenge possible, I do not encourage betraying partner to disclose. Too dangerous. (181)
32. Prior to individual session, I inform both partners of my "no secrets" policy. I do not keep secrets for partners. (187)
33. I would refer for individual therapy to preserve the trust of the couple. (192)
34. I go to what we decided. (211)
35. Change focus of conjoint work until affair is disclosed or terminated. (213)

APPENDIX K
DILEMMA # 5: VERBATIM WRITTEN-IN RESPONSES

IPS Qualitative Data ("Other" responses—In addition to the responses provided in the IPS, the following information was written in by the respondent. All IPS were numbered sequentially upon receipt from survey respondents—the number in parenthesis below refers to the specific IPS from which the information was taken.)

Dilemma # 5: During couples therapy, either through an individual session and/or through another means of direct reporting/admission by the betraying partner, you and the betraying partner agree that an affair is to be disclosed to the betrayed partner. He/she wants to wait. You…(Provided responses: Wait indefinitely and continue conjoint therapy…it's his/her call./Set a deadline by which time the affair must be disclosed or ended…or conjoint therapy will terminate./Set a deadline by which time the affair must be disclosed or the course of therapy will change./Stop conjoint therapy and offer the partners individual therapy./Other). Other:

1. Refer if betraying partner will not work to disclose n next conjoint session. (11)
2. I don't set deadlines. I see discussion of affairs as destructive unless necessary. If spouse suspects then I encourage disclosure. (14)
3. Always next session. (19)
4. If affair is not currently going on, no need to disclose. (34)
5. Answer depends if affair is ongoing. (44)
6. Promote discussion/intentional leading to supportive environment for disclosure. (46)
7. Explore reasons for resistance of disclosure. (54)
8. At start of therapy, I set a treatment boundary: "I will not keep secrets." (68)
9. Assess on a case-by-case basis. Would want to hear from the client what woks. He/she would need to do to disclose the affair and work to obtain a commitment regarding when/how to disclose. Refer for individual therapy. (78)
10. Discuss clients' needs and agenda and determine options for his/her solutions as most clients report this at intake as presenting problems. (86)
11. Give individuals and stop conjoint if agreed to by both partners. (119)
12. Deadlines don't work—Offer support/encourage disclosure. (135)
13. "Demand" disclosure at next session. (156)
14. Exception would be to stop conjoint therapy and offer the partner individual therapy if either was unstable emotionally. (181)
15. Rebuild relationship so both can tolerate disclosure/indiscretion and handle resolution. (198)
16. Or refer. (192)

17. Consult with colleague. (210)
18. Depends on contract. (211)

APPENDIX L
DILEMMA # 6: VERBATIM WRITTEN-IN RESPONSES

IPS Qualitative Data ("Other" responses—In addition to the responses provided in the IPS, the following information was written in by the respondent. All IPS were numbered sequentially upon receipt from survey respondents—the number in parenthesis below refers to the specific IPS from which the information was taken.)

Dilemma # 6: You are coaching the betraying partner on ways to make disclosure to the betraying partner about his/her affair. How much information do you recommend be shared with his/her partner? (Responses provided: Admit to the affair./Only important facts./All details about expenditures./All details about gifts, I love you's, etc./All details about any possible Sexually Transmitted Infections./All details pertaining to the occurrence of pregnancy./All details pertaining to the births of any children./All information pertaining to who knows about the affair (friends, family, etc.)./All information pertaining to the places that the rendezvous occurred./All information pertaining to what activities took place in the marital/relationship home./None…as little as possible./Discourage disclosure altogether./Ask the betrayed partner how much he/she wants to know./Let the betraying partner decide how much he/she wants to share./ Other.) Other:

1. Handle in couple session. (1)
2. All details as long as it isn't voyeuristic. (5)
3. Much of what I encourage is informed by how much the betrayed partner wants or can tolerate knowing. (42)
4. Depends on dynamics. (53)
5. Regarding important facts: What are the important facts? (54)
6. I recommend that the betraying partner answer all questions asked. (58)
7. Discuss problems of disclosure information. Too much information is damaging and too little is anxiety producing. (59)
8. If I am working with an individual, I see what he needs to do to "come clean" and advise him/her about what he/she needs to do to negotiate with the betrayed partner and what he/she needs to do to rebuild trust. If this occurs in couples therapy, I would work with both towards a common goal to rebuild trust. (78)
9. All of the options (b-k) are at the betrayed partner's discretion. I try to get to know what they want to know. Not done lightly. (81)
10. None or as little as possible and discourage disclosure only with one partner's night stand when the betrayed partner doesn't ask and betraying partner is disclosing primarily to relieve their conscience. (82)

11. Discourage disclosure only if betrayed partner has terminal illness or if the affair is 30 years old. (65)
12. Help client generate his/her own ideas about ways they prefer to disclose and to what extent. (86)
13. Avoid the graphic details. (108)
14. Disclose information based on what the betrayed partner wants to know. (126)
15. Depends on how much and what details the betrayed partner wants to hear. (138)
16. Depends so much on situation. Most of this depends on what person wants to know. (139)
17. All information the spouse wants to know. (143)
18. Follow the lead of what the betrayed needs to know but discourage revisiting questions over and over. (144)
19. Judgment call-Betrayed partner can (& often do) become obsessed with all details. (181)
20. All details about experience is that are pertinent to couples finances. (187)
21. I would leave amount up to the couple but would explicitly encourage disclosing of STD's and pregnancies. (209)
22. Very situation oriented-I don't believe details are helpful. (210)
23. Depends. (211)

APPENDIX M
DILEMMA # 7: VERBATIM WRITTEN-IN RESPONSES

IPS Qualitative Data ("Other" responses … In addition to the responses provided in the IPS, the following information was written in by the respondent. All IPS were numbered sequentially upon receipt from survey respondents … the number in parenthesis below refers to the specific IPS from which the information was taken.)

Dilemma # 7: In couples therapy, one partner suspects his/her partner is having an affair, believes you may know about it (and you do), and asks you directly if his/her partner is having the affair. You… (Responses provided: Avoid telling the truth./Tell the truth./Ask him/her to ask his/her partner./Say…"That's not for me to answer."/Refer the couple to another therapist./Tell him/her that confidentiality prohibits you from discussing it./Other.) Other:

1. I try to avoid this and have an explicit policy on secrets, not seeing folks in treatment alone except in assessment. (6)
2. I hope I never put myself in this situation! Would have agreement on open sharing before starting. (11)
3. Discuss with partner-open discussion. (14)
4. Never happens. (19)
5. Tell the betraying partner I will not collude and if asked will tell the truth. (21)
6. Remind him/her about previously discussed "secrets policy." (22)
7. Keeping one person's secret compromises therapy-so if the unfaithful partner is having an affair, I would terminate couples therapy. (34)
8. Depends on what brings about the question. (44)
9. If true, refer. (46)
10. Ask him/her to ask his/her partner and support the right to know. (48)
11. I would disclose my policy from the outset: no secrets. (48)
12. I've already told the betraying partner that I can't keep secrets in conjoint therapy and encourage disclosure if conjoint therapy is to occur. (58)
13. Not a good statement-legally. You can't disclose under the law. (72)
14. Refer to the disclosure guidelines. (78)
15. I won't keep secrets. If I'm asked I'll tell what I know. You never want to be here. (81)
16. Again, now covered by my office policies statement. (82)
17. At onset of therapy I share rules re: this. Usually stabilizes the situation. (82)
18. Tell the truth…confidentiality prohibits it…and ask him/her to ask his/her partner-tell the client I don't know if I don't know. (86)
19. Ask his/her response to what if answer is yes or no. (88)

20. Ask him/her: "Why don't you trust your intuition? What do you believe? (88)
21. I always preface couples treatment by saying I don't keep secrets. (96)
22. Review original limits of confidentiality. (100)
23. Tell partner that discussion of affairs is premature at this point. (104)
24. Establish ground rules in therapy. Any disclosure of affair is couple information. (127)
25. My evasiveness could no doubt lead to further suspiciousness by the betraying partner, that's ok. (138)
26. Avoid this position by disclosing early a protocol for couples therapy (no secrets.) (143)
27. Insist on betrayer disclosing before this happens. (144)
28. I can't answer for reasons of confidentiality. (147)
29. Ask "why" would you ask me rather than your partner. (148)
30. I would ask the betraying partner what he/she wanted done with the question. (152)
31. Private meetings with betrayer are unacceptable. (155)
32. I assume this is a couple's session. (172)
33. I wouldn't know about it …either the betrayer must plan to disclose or end the affair. (179)
34. Encourage openness regarding basics and/or "you can tell them in session, if not privately." (197)
35. Refer to another therapist. If betrayed partner still insists on knowing from therapist. (208)
36. I let couples know before treatment that I will not keep secrets for either of them. I don't see it as my place to reveal it. I won't provide treatment unless it's revealed. (209)
37. Remind them we discussed boundaries and encourage the betrayed partner to talk to the other partner. Ask why the partner is asking me and explore it. (211)

APPENDIX N
DILEMMA # 8: VERBATIM WRITTEN-IN RESPONSES

IPS Qualitative Data ("Other" responses—In addition to the responses provided in the IPS, the following information was written in by the respondent. All IPS were numbered sequentially upon receipt from survey respondents—the number in parenthesis below refers to the specific IPS from which the information was taken.)

Dilemma # 8: During couples therapy, where either through an individual session and/or through another means of direct reporting/admission you learn the betraying partner wants to disclose his/her affair to the betrayed partner, you… (Responses provided: Point out the risks involved in disclosing the affair./Encourage disclosure without reservations./Point out the advantages of disclosing the affair./Discourage disclosure…point out the disadvantages./Other). Other:

1. Process the risks and advantages with betraying partner. (1)
2. Explore reasons, feelings, and dynamics behind the wish to disclose affair. (6)
3. Explore purpose of disclosure. (10)
4. Discuss options and consequences. (15)
5. I look more deeply at the disclosure of emotional secrets. (17)
6. Discuss and let clients decide. Let client know disclosure is important if therapy continues. (27)
7. Disclose only if health risks concerned. (34)
8. Depends on if affair is ongoing. (44)
9. Discuss advantages and let them decide. (57)
10. Encourage individual to discuss all aspects … what do you have to gain? What will you lose? (59)
11. I explore…alone…encouraging disclosure (66)
12. Explore it from a cost/benefit analysis. It's the client's decision. (78)
13. Help clients identify their values, options, benefits, and risks of disclosure. (86)
14. Discuss consequences. Help prepare. Encourage disclosure. (96)
15. Review original limits of confidentiality. (100)
16. Discuss and plan/anticipate and prepare for reactions. (126)
17. Discuss pros and cons of disclosure and how to tell/not tell. (140)
18. Protocol generally…I will not work with you if you are having an affair. (143)
19. Depends on the depth and length of the affair-if rare slip discuss reasons, boundaries, limits. (167)
20. You can tell them privately or in session. (197)
21. Discourage disclosure …point out the disadvantages when there is a danger of physical abuse. (200)

22. Hard to answer-I think at times it is helpful for the affair to be disclosed. (210)
23. Ask to explore motivating and meaning. (211)

APPENDIX O
DILEMMA # 9: VERBATIM WRITTEN-IN RESPONSES

IPS Qualitative Data ("Other" responses … In addition to the responses provided in the IPS, the following information was written in by the respondent. All IPS were numbered sequentially upon receipt from survey respondents … the number in parenthesis below refers to the specific IPS from which the information was taken.)

Dilemma # 9: In couples therapy, when you are aware of an affair and, even though no history of violence is present, you believe violence could result from disclosure, you…(Responses provided: Discourage any type of disclosure of the affair for fear of someone getting hurt./Encourage disclosure under certain conditions of safety planning./Require disclosure of the affair for therapy to continue…irrespective of possible violence./Insist on no disclosure./Other.) Other:

1. Not enough info to say what I would do…unclear question. (6)
2. Could not continue therapy under these conditions. (11)
3. Deal with it in couples therapy. (19)
4. Treat violence issue-discuss these and their implications (44)
5. Explore it with the individual although since I primarily work with both partners in the room, it is unlikely I would know about an affair if the partner didn't (78)
6. Discourage any type of disclosure of the affair for fear of someone getting hurt until safety issues are addressed. (81)
7. Help client identify consequences of disclosure, assess safety issues, and develop a plan for safety. (86)
8. No experience as described. (100)
9. Refer for work to individual…betrayed spouse to explore consequences and manner of disclosure and game plan for safety. (138)
10. Discuss pros/cons of disclosure and how to tell/not to tell. (140)
11. Therapists should avoid being triangled into spouse's affairs from early on (assessment). These are problems that occur when therapists are unclear regarding what cases they take on. (143)
12. Discuss the dangers I perceive. (148)
13. Important to know if violence could occur and deal with the violence first. (149)
14. Depends on why affair happened and continuation of relationship. (163)
15. I don't know what I'd do. (171)
16. This is a discretionary question or issue. Hard to answer definitively. (181)
17. Consult a Domestic Violence expert. (187)
18. Always get an agreement of "no hard" from the couple before conjoint therapy begins. (193)

19. I would really discuss the issue of violence with each partner and look at the history of violence in the family. (203)
20. Consult. (210)
21. Explore the issue. (211)

APPENDIX P
DILEMMA # 10: VERBATIM WRITTEN-IN RESPONSES

IPS Qualitative Data ("Other" responses—In addition to the responses provided in the IPS, the following information was written in by the respondent. All IPS were numbered sequentially upon receipt from survey respondents—the number in parenthesis below refers to the specific IPS from which the information was taken.)

Dilemma # 10: In couples therapy, the couple asks advice on whether or not to tell their children about the affair. You…(Responses provided: Encourage them to tell nothing to the children./Encourage them to wait and decide whether or not to tell the children./Encourage them to tell the adult (over 21 years of age) children/Encourage them to tell the older (ages 13-21 years) children./Encourage them to tell the younger (under 13 years of age) children./ Explore their motives for wanting to tell and then advise them./Other). Other:

1. Difficult to answer, depends on how much they actually know. (7)
2. Affairs are not the business of children, they are between adults and adult relationships. (14)
3. The children probably know and/or suspect or are asking questions…endorse being honest. (21)
4. Let them decide. (27)
5. Depends on what the children already know…and have seen. (50)
6. Get some information on state of mind of the children. (54)
7. Depends on the ages of the children, nature of the affair, etc. (56)
8. Cross out "then advise them". (59)
9. Explore their motive and work with them to make the best decision through looking at a variety of factors, including timing. (78)
10. Circumstances will determine the need to disclose to children and when. (83)
11. Along with disclosure recommend telling older children, their actions were wrong and ask for forgiveness for being poor role model. (65)
12. Explore values and consequences of disclosing…rarely encourage them one way or another. (86)
13. Point out the advantages and disadvantages and help them decide. (124)
14. Disclose (acknowledge only) affairs not a secret from family and help reestablish boundaries and trust. (127)
15. Depends on age of children. (138)
16. I don't advise…I talk about the advantages and disadvantages. (139)
17. Chances are older children know. (141)
18. Explore pros/cons of telling children. (148)

19. This is a sticky one and would need ore info first. (149)
20. Most often children know or suspect something much worse. (167)
21. Do more exploration and thinking through to their own decision. (170).
22. Educate on parental responsibilities. (187)
23. Respect boundary issues between generations. (190)
24. The word "encourage" is the problem here. I would tell them that it's their think to tell…explore options and have them decide together. (197)
25. Explore the issue. (211)

APPENDIX Q
DILEMMA # 11: VERBATIM WRITTEN-IN RESPONSES

IPS Qualitative Data ("Other" responses—In addition to the responses provided in the IPS, the following information was written in by the respondent. All IPS were numbered sequentially upon receipt from survey respondents—the number in parenthesis below refers to the specific IPS from which the information was taken.)

Dilemma # 11: In couples therapy, the couple asks for advice on whether or not to tell their extended family about an affair. You…(Responses provided: Encourage them to disclose everything immediately./Encourage them to disclose nothing. It's nobody's business./Encourage them to disclose to some of their family members as they see fit./Encourage them to wait and disclose until they can decide what information they want to disclose./Explore their motives for wanting to tell and then advise them./Other). Other:

1. Let them decide. (27)
2. Cross out "advise them." (59)
3. Help them explore the cost/benefit, explore family of origin issues to determine whether there is a pattern, etc. (78)
4. Acknowledge with disclosure that actions were wrong, ask for forgiveness and for continued support as the couple works on restoring the relationship. (5)
5. Point advantages and disadvantages. (124)
6. Where not a secret from certain extended family, acknowledge and indicate new boundaries. (127)
7. I don't advise, I talk regarding advantages and disadvantages. (139)
8. Explain the pros/cons of telling extended family members. (148)
9. Not sure of their judgment. (149)
10. Respect and reinforce appropriate boundaries between generations. (190)
11. I would have trouble encouraging. (197)
12. Explore options together but they ultimately decide. (197)
13. Explore the issues. (211)

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BIOGRAPHICAL SKETCH

Rosaria Carlone Upchurch was born Maria Rosaria Carlone on November 17, 1955, in S. Bartolomeo in Galdo (BN), Italy. She is the third surviving child of Fiorenzo Umberto Carlone and Angelina Pepe in Carlone. Together with her family, she immigrated to the United States in 1967. Her family settled in Millburn, New Jersey, where she entered the American school system as a fifth grader. In 1975, when Rosaria's parents moved back to Italy, she remained in the United States and became self-supporting, working as a waitress while pursuing a college degree. She attended Montclair State College, Upper Montclair, New Jersey, and graduated in 1979, receiving a Bachelor of Arts degree, with honors. Rosaria majored in both Spanish and Italian, and minored in psychology. She speaks English, Italian, Spanish, and French.

Rosaria and Paul Nehring Upchurch were married in August of 1979. In November 1979, they moved to Daytona Beach, Florida, where Paul and two partners started a law firm. Rosaria worked at the firm as the office manager for 3 years before returning to school.

In 1987, Rosaria earned a Master of Education (M. Ed.) in community mental health and counseling from Stetson University in DeLand, Florida. She continued attending classes at Stetson University beyond graduation and received a certification in marriage and family therapy. In her career, Rosaria has worked full- and part-time in community mental health agencies, and has also been part of the clinical staff of a managed-care facility.

Rosaria received a Florida license to practice marriage and family therapy in 1989. In 1995, she became a certified Imago relationship therapist and began specializing in couples therapy. She owns and operates a successful, full-time marriage and family practice in the Daytona Beach area. Her work includes therapy with couples, families, individuals, and adolescents. She consults with for profit and nonprofit groups and organizations, and she leads sessions in conflict management, team building, and organizational development. She also supervises registered interns. She is a clinical member of the American Association of Marriage and Family Therapy (AAMFT) and a professional member of the American Counseling Association (ACA).

Rosaria is currently an adjunct professor at the University of Central Florida, where she teaches graduate courses in family therapy and cross cultural psychology in the Clinical Psychology and the Education Departments.

While in the doctoral program at the University of Florida, Rosaria received recognition as a Chi Sigma Iota Outstanding Doctoral Student and as a Chi Sigma Iota Outstanding Practitioner. She assisted in the teaching of eight graduate classes, served as a mentor in the multicultural lab, and served as a clinical supervisor in the Advanced Family Therapy Clinic for six semesters. She was a regular guest in academic classes, where she presented programs and lectures on professional development, communication, Imago relationship therapy, private practice, marriage and family issues, etc. She also made possible several educational programs that were delivered at the University by other speakers, and made a presentation on family issues in another UF department.

Rosaria has been volunteering in her community for the past 25 years. For the past 10 years, she has been serving as a director of the FUTURES Education Foundation

for Volusia County Schools. She has been chairman of the Tomorrow's Leaders Committee, a program for high achieving 11th graders from the nine area High Schools. In 1997, she served on the Superintendent Task Force on Middle Schools, and as chairman of its Emotional and Social Development Committee. Her other involvement in the schools include PTA president, chairman of Parent Advisory Committee, and member of school improvement committees. She has also provided crisis support and intervention on many other projects. As a volunteer, she has contributed to the efforts to bully-proof schools, educate parents and staff, and enrich students on a variety of social and psychological issues.

Rosaria's other volunteer activities have included high-level leadership positions in community mobilization of grassroots efforts pertaining to substance-abuse addicted pregnant and postpartum mothers and their babies, and eating disorders prevention and services. She has served in an advisory capacity to county government regarding funding for children's services and was a charter member of the Nominee Review Qualification Committee for the Board of Health and Human Services (formerly HRS) District 12 under Governor Lawton Childs.

Rosaria received a proclamation from the Volusia County Council for her work with cocaine babies, and she also received a J. C. Penney Golden Rule Award for her volunteer work in social services. She has served as president of the Junior League of Daytona Beach (JLDB) twice. She is currently a sustaining member of JLDB and of The Association of Junior Leagues International.

Rosaria regularly presents educational programs in her community to civic and professional groups on issues such as families, relationships, stress, women's issues, sexual assault, substance abuse, and parenting.

Rosaria has been married to Paul for 25 years, and together they have two children: Megan, who is a freshman at Wake Forest University, where she plays varsity women's soccer; and Rocky, who is a sophomore in the International Baccalaureate Program at Spruce Creek High School, Port Orange, Florida.

Rosaria's plans are to continue working in her private practice and to continue her academic teaching. She envisions conducting research in the areas of infidelity, multiculturalism, and leadership development. She also dreams of writing works of fiction and, at some point in her journey, serving in public office. Rosaria's mission statement is "To direct energy in the creation of hope, joy, and love."

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Silvia Echevarria-Doan, Chair
Associate Professor of Counselor Education

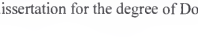
I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Ellen Amatea
Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

M. David Miller
Professor of Educational Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



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This dissertation was submitted to the Graduate Faculty of the College of Education and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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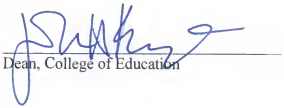

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